

# **GEORGIA CHILD FATALITY REVIEW PANEL**

Annual Report  
Calendar Year 2001



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# GEORGIA CHILD FATALITY REVIEW PANEL

## MISSION

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.



## Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible.

These include:

- Dr. John T. Carter, Ph.D., Jill Andrews, Mathew Sacrinty, and associates of the Epidemiology Department of Emory University, Rollins School of Public Health
- All the members of county child abuse protocol and child fatality review committees
- All the public/private agencies that have so willingly collaborated with this office and provided support

# GEORGIA CHILD FATALITY REVIEW PANEL

## MEMBERS

Chairperson

**Duncan D. Wheale**

Superior Court Judge, Augusta Judicial Circuit

**Ms. DeAlvah Simms**

Child Advocate for the  
Protection of Children<sup>3</sup>

**Dr. Todd Jarrell, M.D.**

Board Chair, Dept. of Human Resources<sup>3</sup>

**Sharon Hill, Associate Judge**  
Fulton County Juvenile Court

**Mr. Vernon Keenan, Acting Director**  
Georgia Bureau of Investigation<sup>3</sup>

**Ms. Carol O. Ball,**  
SAFE KIDS of GA.

**Representative Georganna T. Sinkfield**  
Member, GA House of Representatives<sup>2</sup>

**Kathleen Toomey, M.D.**  
Director, Division of Public Health<sup>3</sup>

**Ms. Juanita Blount-Clark, Director**  
Division of Family & Children Services<sup>3</sup>

**Ms. Vanita Hullander**  
Coroner, Catoosa County

**Dr. Kris Sperry**  
Chief Medical Examiner<sup>3</sup>, GBI

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Criminal Justice Coordinating Council<sup>3</sup>

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**Detective Charles Spann**  
Cobb County Department of Public Safety

**Senator Nadine Thomas**  
Member, GA Senate<sup>1</sup>

**Mr. J. Tom Morgan**  
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The Georgia Child Fatality Review Panel is an appointed body of 16 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

<sup>1</sup> Appointed by the Lieutenant Governor

<sup>2</sup> Appointed by the Speaker of the House of Representatives

<sup>3</sup> Ex-Officio



# Georgia Child Fatality Review Panel

December 10, 2002

Chairperson:

**Judge Duncan Wheale**  
Superior Court  
Augusta Judicial Circuit

Co-Chair:

**Detective Charles Spann**  
Cobb County Department of  
Public Safety

Secretary:

**Carol O. Ball**  
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Members:

**Dr. Randell Alexander**  
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**Juanita Blount-Clark,**  
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**L. Gale Buckner**  
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**Sharon N. Hill**  
Associate Judge  
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**Vernon M. Keenan**  
Actg. Director, GBI

**J. Tom Morgan,**  
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**Rep. Georganna Sinkfield**  
Member, GA House of  
Representatives

**Dr. Kris Sperry**  
Chief Medical Examiner  
GBI

**Senator Nadine Thomas**  
Member, GA Senate

**Dr. Kathleen Toomey,**  
Director  
Division of Public Health

Dear Governor and Members of the Georgia General Assembly,

You will see in this report that 1,799 children died in Georgia in 2001. Many of those deaths could have been prevented. Ninety-four children died from suspected or confirmed abuse; 71 died from homicides; 34 from suicides; and 408 children's deaths were either "definitely" or "possibly" preventable. How much should we spend in resources – time and money – to prevent 400 children from dying each year?

Before this panel was formed, we had no way of tracking or investigating these deaths. With the continued support we receive from you each year, our abilities to track, investigate and help prevent children from dying will improve.

This year we have identified several areas that should significantly increase the results all of us want to achieve. First, we realized our staff was spending most of its time getting the proper reports from 159 county Child Fatality Review Committees. In October we received funding from the Governor's contingency fund that will allow us to purchase software, so all county committees will electronically file their reports. The report must be completed properly, or the software will not allow it to be filed. Second, we realized that there was no proper chain of command at the local level to ensure that committee meetings were regularly called, reports were properly prepared, and that there was continuity as new members came onto the committees. We have proposed legislation that will allow district attorneys to be chairpersons of each committee in that district attorney's judicial circuit. The counsel for the district attorneys has agreed to support this legislation. Finally, we also learned that there simply were some members of the local committees who refused to do what was required of them. By law, there is one Superior Court judge sitting on the state panel. We have proposed legislation that will allow that Superior Court judge to hold in contempt any member of a local committee in Georgia who refuses to provide the information necessary to have the reports completed. With these three changes, we believe we can increase significantly the reporting process, and ultimately we can then work on the local level to address problems, in hopes of bringing the number of deaths down each year.

We meet four times a year. Our meetings are in the Atlanta area. We welcome you or members of your staff to attend any of our meetings. If that is not possible, we welcome your questions and comments and look forward to being your partners in 2003.

Sincerely,

Duncan D. Wheale  
Chairman

DDW/sa

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**P**revention - A popular term used today that we're all familiar with, and whose essence we subscribe to in many areas of our lives...or do we really? Prevention necessitates purposeful thought and plan if it is to be successful. Prevention often means foregoing the "norm" and our "business as usual" attitude, and requires us to construct a new paradigm to direct our actions.

The term "prevention" is frequently used in discussions regarding safety and protection of children. Study after study has shown that employing prevention measures to safeguard children are much less costly in the long run. Not only are they less costly economically, but also emotionally and socially for families, communities, and the state. Prevention also produces a more desirable outcome - healthy children growing up to become productive adults. Too often our budgets, policies, and procedures, belie our declaration regarding prevention. A look at the number of child deaths both nationally and in Georgia reveals a need for all of us - government, communities, individuals - to develop a sound, well thoughtout, prevention plan.

During this past legislative session, the Governor and Georgia General Assembly again increased funding for child protection. Increased funding is essential to adequately serve and protect children who have been abused. However, to protect children from the risk of all injuries, including abuse, our resolve must be to invest the resources necessary on the front end (prevention) that will afford our children an opportunity to survive and become healthy adults.

In 2001, 1,799 children died in Georgia according to Vital Records. The Georgia Child Fatality Review Panel publishes an annual report which contains detailed information regarding deaths which were sudden, unexpected, and/or unexplained. This information is compiled from reports submitted by local county child fatality review committees. The Georgia Child Fatality Review Panel is charged with not only tracking the numbers and causes of child deaths, but also identifying and recommending prevention strategies that could reduce the number of child deaths.

## Key Findings

### Fatal Child Abuse/Neglect

**Child fatality review committees** determined that 94 child deaths resulted from suspected or confirmed abuse and/or neglect. Thirty-seven (37) of those abuse related deaths were ruled homicides. Children under the age of 5 accounted for (78%) of homicides resulting from abuse. Perpetrators were identified in 47 of the child abuse related deaths and 63% of those perpetrators were parents.

### Natural

**Death certificate data** indicated a total of 1,322 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,079) of those deaths. The leading causes of infant deaths continued to be congenital anomalies, low birth weight, and prematurity. There were 116 SIDS deaths.

**Child fatality review committees** reviewed 186 deaths from natural causes. One hundred-three (103) of those deaths were SIDS. Committees are required to review all SIDS deaths, and medical deaths that are unexpected or unattended by a physician.

### Unintentional Injuries

**Death certificate data** indicated that 63% of deaths (415) in children ages 1 – 17 resulted from injuries. Seventy-six percent (76%) of all injuries in this age group resulting in death were unintentional. The 3 leading causes of unintentional injury related deaths in all age groups included:

- 224 motor vehicle incidents
- 40 Drowning Incidents
- 31 Suffocations

The most marked increase in deaths from 2000 was deaths from poisoning (43%), and the most marked decrease was suffocation (21%).

**Child fatality review committees** reviewed 264 deaths determined to have resulted from unintentional injuries.

## Intentional Injuries

**Death certificate data** indicated 105 children died from injuries intentionally inflicted by themselves or by others (suicide and homicide). In 2001, there were 71 homicides ( a 7% decrease from 2000), and 34 suicides (a 13% increase).

**Child fatality review committees** reviewed 87 deaths from intentional causes – 54 homicides and 33 suicides.

## Firearm Deaths

**Death certificate data** indicated firearms were used in 47 child deaths. Twenty-seven (27) of those deaths were ruled homicides, fifteen (15) suicides, and five (5) unintentional shootings.

**Child fatality review committees** reviewed 37 firearm related deaths. Eighty-seven percent (87%) were intentional. The type of firearm was identified in 35 of the 37 reviewed firearm related deaths. Handguns were most frequently used (21 of the 37 reviewed firearm deaths).

## Preventability

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in 530 of the 537 child deaths reviewed. Child fatality review committees determined that 410 (77%) of the 530 child deaths were definitely or possibly preventable.

## Agency Involvement/Intervention

**Child fatality review committees** reported that in 82% (77) child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 6 instances in which agency intervention could have prevented child abuse/neglect related deaths.

# ACCOMPLISHMENTS, RECOMMENDATIONS, AND GOALS OF THE GEORGIA CHILD FATALITY REVIEW PANEL

## Accomplishments:

1. Secured funding for on-line reporting system to assist counties with filing child fatality reports
2. Successfully engaged in collaborative efforts with other agencies, including:
  - Access to the GBI autopsy database
  - Agreement with GBI to assist with further development of child death investigation teams across the state
3. More timely response in provision of training and consultation of county child fatality review committees
4. Eight percent (8%) increase in county reporting compliance
5. Wider distribution of Panel's Annual Report (from 500 in year 2000 to 1000 copies in 2001)

## Legislative Recommendations:

1. Fully implement recommendations of the Child Protective Service Task Force to improve the state's ability to protect children from child abuse and neglect
2. Fund expansion of home-based family support models that promote and enable appropriate parenting skills for prevention of child abuse and neglect
3. Require fences and gates in public and private swimming pools statewide
4. Require an autopsy, including toxicology studies, for every death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician. Further, require complete skeletal x-rays (following established pediatric and radiological protocol), of the bodies of children who died before their second birthday
5. Pass a "Child Endangerment Law" to hold adults accountable who knowingly create or allow children to be placed in dangerous situations
6. Provide sufficient funding to the Georgia Child Fatality Review Panel to fulfill statutory requirements
7. Expand funding for mental health services for children, especially those identified as "at risk"

## Agency Recommendations:

1. DFCS: The Panel recommends that all cases of newborns whose mothers have a positive drug screen be referred to Juvenile Court
2. DFCS: The Panel recommends that when a child dies due to a parent or caretaker's neglect or aggression, ongoing efforts be made to visit the surviving children in that home to assess their safety and well-being, and enable voluntary referrals to appropriate services
3. Coroner & Medical Examiner's Office: The Panel recommends that a death scene investigation be conducted for any child death suspected of being accidental, a homicide, or of unknown causes. No case should be classified as SIDS unless a death scene investigation and review of the clinical circumstances are completed

## Goals:

1. Development of a "Best Practices" manual for county child abuse protocol committees
2. Publish and distribute "Child Fatality Review Policy and Procedures" manual
3. Facilitate a 10% increase in county reporting of child fatalities

## CHILD DEATHS IN GEORGIA

Child death in Georgia has been the focus of many news articles, task forces, and legislative efforts. In 2001, 1,799 children died in Georgia, which was equivalent to almost five child deaths a day. Most of those deaths were due to medical causes (1,206), and occurred among infants (963). The remaining deaths (593) were the main focus of child fatality review committees. (Medical deaths are indicated for review only if unexpected or unattended by a physician.) The purpose of the child fatality review process is to analyze all circumstances of child deaths. This process is critical in identifying prevention strategies that can help reduce these needless deaths and improve the well-being of Georgia's future generations.

### Information Sources

Child fatality review reports are the primary source of data for this report. Child fatality review reports are submitted on deaths that are identified by the county coroner, medical examiner, or child fatality review committee. In addition to the SIDS and unintentional/intentional deaths, the committee may identify other deaths as appropriate for review. Child fatality review reports provide details of the cause and circumstance of death, supervision at time of death, prior history of abuse or neglect, perpetrator(s) in child abuse-related deaths, and prior agency involvement. Reports also contain information regarding whether a

death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

The 2001 Vital Records death certificate file was used to describe all child deaths. This file was also used to identify the subset of deaths that met the criteria for review. The child fatality review file was linked with the death certificate file. The death certificate provides demographic information and states the official cause of death. These two data sources do not always agree on the cause or manner of death. Child fatality review committees determined 4 child deaths to have resulted from a different cause than that reported on the death certificate.

Of the 1,799 child death certificates filed in 2001, 593 met the criteria requiring review. Child fatality review committees reviewed 443 (75%) of those eligible deaths, in addition to 11 deaths for which no death certificate was issued, and 83 deaths related to medical causes. A total of 537 deaths were reviewed and are included in Appendix C.2 of this report.

Except as noted, information and figures from child fatality review reports are designated by the term "Reviewed Deaths", and include a total of 454 child deaths (injury-related and SIDS). All information on "Trends" is based on death certificate data.

## SUMMARY OF ALL DEATHS

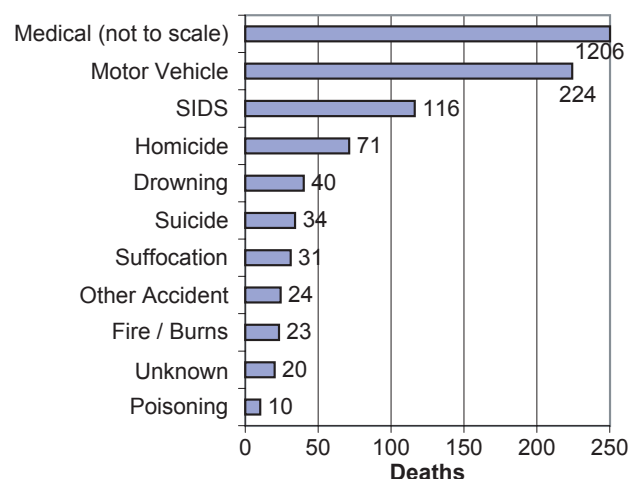
Figure 1 shows the causes of all 1,799 child deaths in Georgia in 2001. Natural causes were responsible for 73% (1,322) of all deaths, with 82% (1079) of those deaths occurring before age one.

The term "medical" when used in this report as a cause of death for infants does not include SIDS.

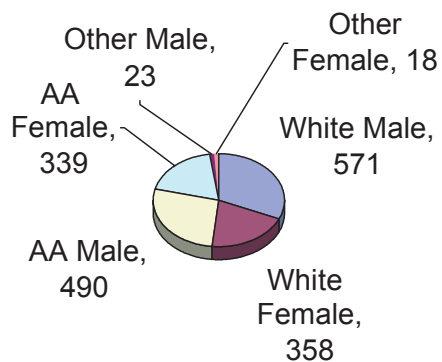
### Findings

- The total number of infant/child deaths (1,799) is higher than the totals for each of the preceding 3 years (an average of 1,734 for 1997 through 2000). In 2001, the largest increase in deaths was associated with motor vehicles (from 195 in 2000 to 224)
- Changes in the number of deaths in other cause categories are consistent with annual fluctuations

**Figure 1. Deaths to Children Under 18 in Georgia**  
**All Causes based on Death Certificate**



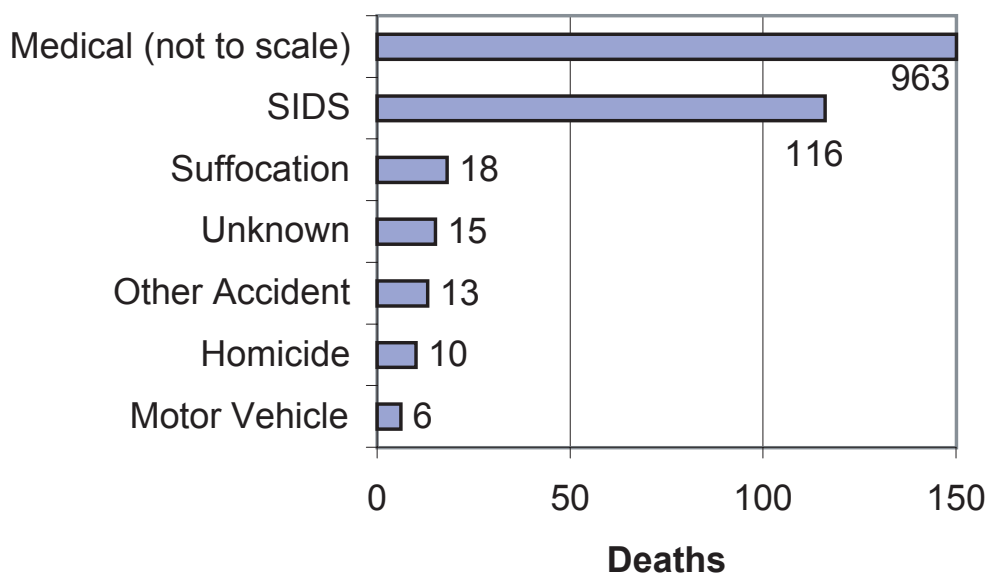
**Figure 2. Race and Gender of All Child Deaths**



**Findings**

- African American children make up 34% of the child population; however, their deaths make up 46% of all child deaths
- Although not shown in the figure, there was an increase in deaths among Hispanic children (85 in 2000 to 95 in 2001)
- Ninety-one (91) of the 95 Hispanic deaths report race as “White”

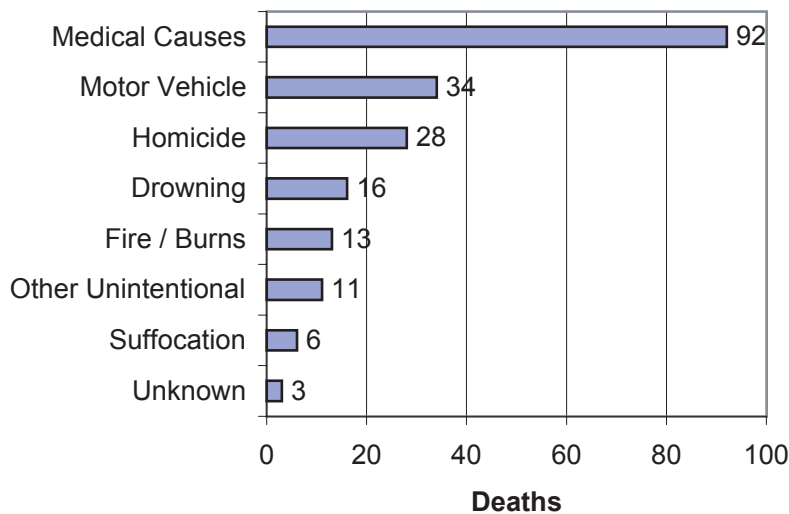
**Figure 3. All Causes of Death, Age < 1**



**Findings**

- Only 62 (5%) infant deaths resulted from unintentional or intentional injuries. This was a slight decrease from last year (65), but higher than the 48 in 1999
- Of defined causes, suffocation (18) represented the largest single injury-related category
- Of the 95 Hispanic deaths discussed in Figure 2 Findings, 76% (73) were due to natural causes, with 78% (57) of those being infant deaths

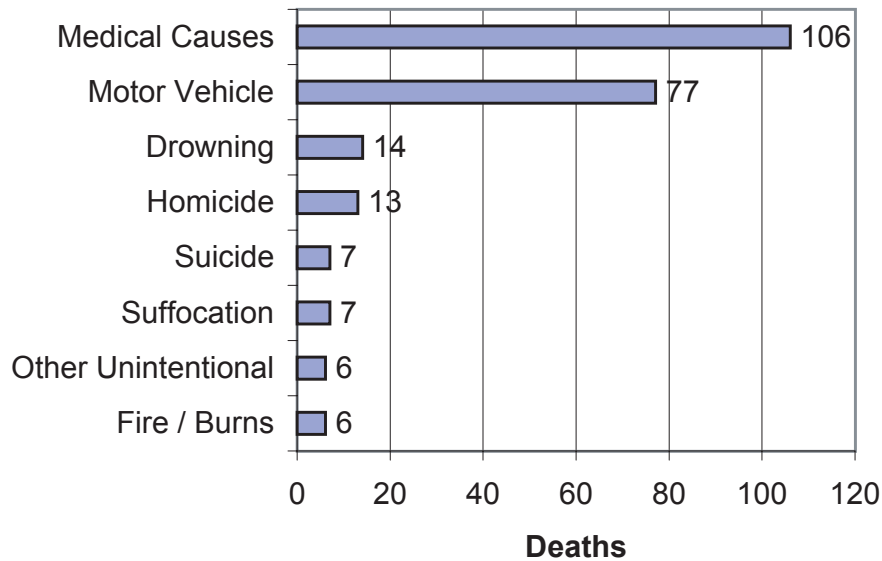
**Figure 4. All Causes of Death, Age 1-4**



**Findings**

- Deaths among this age group increased in 2001 (from 174 in 2000 to 203)
- The largest increase was in homicide deaths - from 16 in 2000 to 28 in 2001
- Deaths due to fire, MV, and drowning also increased

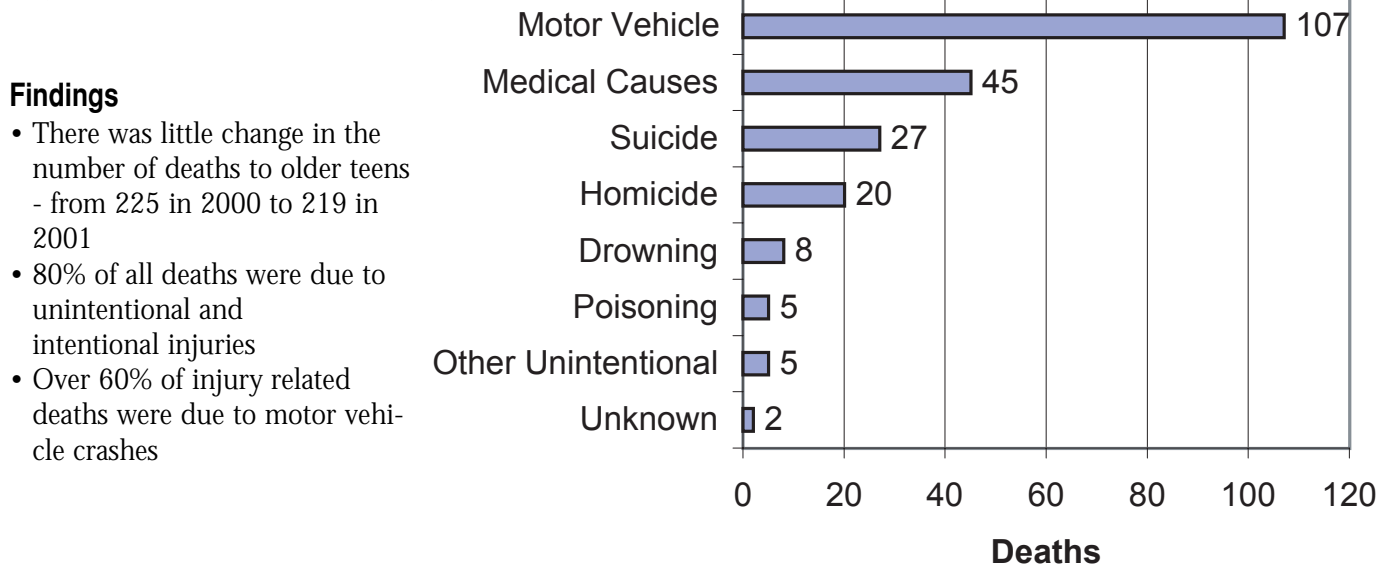
**Figure 5. All Causes of Death, Age 5-14**



**Findings**

- 55% of deaths in this age group were caused by injuries
- 59% of those injuries were motor vehicle related, representing an increase from 2000 (47%)

**Figure 6. All Causes of Death, Age 15-17**



**Findings**

- There was little change in the number of deaths to older teens - from 225 in 2000 to 219 in 2001
- 80% of all deaths were due to unintentional and intentional injuries
- Over 60% of injury related deaths were due to motor vehicle crashes

## ALL 2001 REVIEWED DEATHS

In 2001, 593 of the total 1,799 child deaths met the criteria requiring review (injuries and SIDS) according to death certificate data. Committees filed reports for 75% (443) of those deaths within the reporting period, representing an increase of 8% since calendar year 2000. (This increase is attributed to the availability of more resources to local child fatality review committees for training and technical assistance.) Committees reviewed an additional 94 child deaths for a total of 537 deaths reviewed.

The distribution of child deaths in Georgia is generally proportional to the county population.

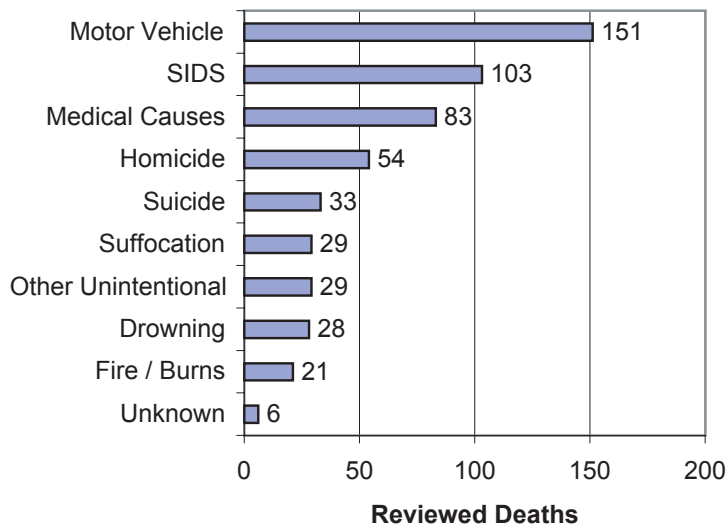
- The 14 counties with 10 or more reviewable deaths in 2001 have 50% of the child population and 44% of all reviewable deaths. Those counties

reviewed 85% (222) of their 262 reviewable deaths. Only one of the 14 counties reviewed less than 50% of the reviewable deaths

- One hundred thirteen (113) counties with from 1 to 9 reviewable deaths had a total of 331 reviewable deaths and reviewed 67% (221) of the deaths. Thirty-four of the 113 counties did not review any of their reviewable deaths
- Nine counties had no child fatalities in 2001, and an additional 23 counties had no child fatalities that met the review criteria

Four hundred fifty-four deaths, (injuries and SIDS), are discussed in the “Reviewed Deaths” sections of this report. Reviews of medical deaths are not included unless noted.

**Figure7. Number of Reviewed Child Deaths by Cause (includes medical)**



### Finding

- Injuries due to motor vehicle incidents continued as a leading cause of death among children

### Preventability

Each child fatality review report asks the team to determine whether the death could have been prevented. Only 7 of the 537 reviews submitted in 2001 omitted this information. Of the remaining 530 reports addressing preventability, teams reported the following:

Definitely Preventable	39%
Possibly Preventable	38%
Not Preventable	23%

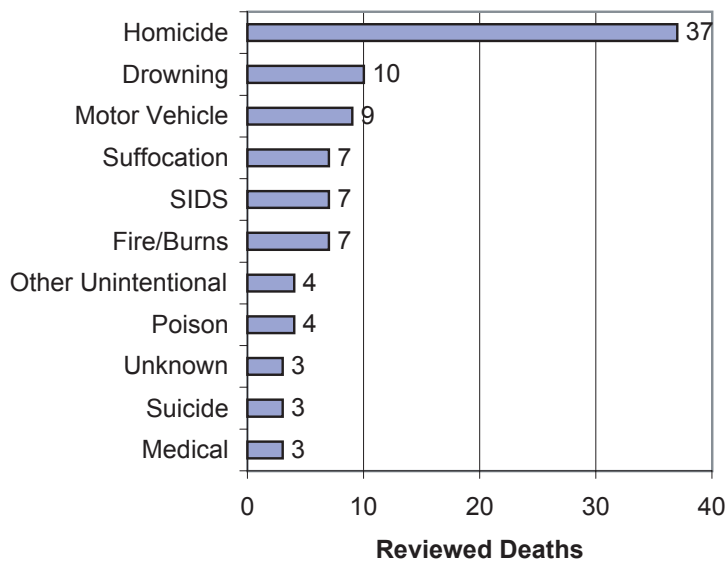
The CFR committees' determination of preventability depends on the cause of death (see Appendix C.4). Less than 5% of the reviewed “Natural” deaths were judged “Definitely Preventable”. However, more than 50% of homicide and unintentional deaths were determined to be “Definitely Preventable”. Fifty (50) of the 58 deaths (86%) with confirmed child abuse were considered to be preventable, while 32% of deaths with no findings of abuse were determined to be definitely preventable.

## CHILD ABUSE AND NEGLECT

In 2001, there were 63,488 cases of child abuse/neglect investigated in Georgia. Thirty-five percent (35%) of those cases were confirmed. Ninety-four (94) reviewed child deaths were determined by Child Fatality Review Committees to have been suspected (36) or confirmed (58) child abuse and/or neglect. (Data on the cause of death,

age, race and gender for those deaths are included in Appendix C.3 of this report.) A history of domestic violence in the home of the decedent was also associated with a committee finding of child abuse. Sixteen percent (16%) of deaths with an abuse finding had a history of domestic violence compared to only 5% of deaths with no abuse findings.

**Figure 8. Circumstances of Reviewed Deaths with Abuse/Neglect Findings**

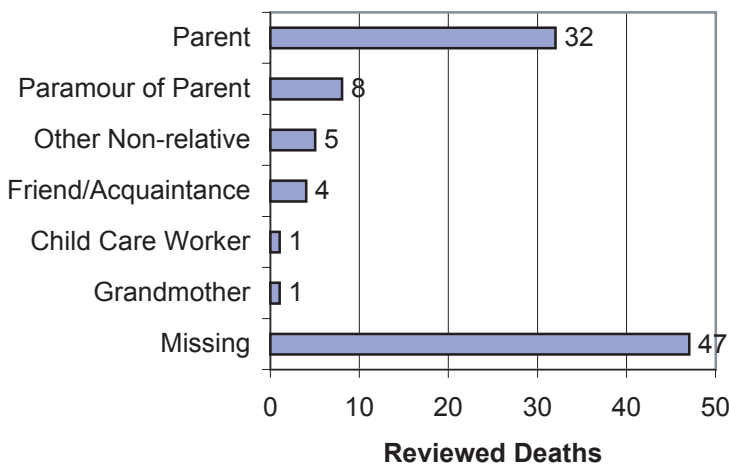


### Findings

- 39% of reviewed deaths with child abuse or neglect findings were homicides
- Of the 37 homicides, 3 were confirmed to be the result of Shaken Baby/Sudden Impact Syndrome, and an additional one as the result of being crushed

## Perpetrators

**Figure 9. Relationship of Perpetrator to Decedent in Reviewed Cases with Abuse and Neglect**

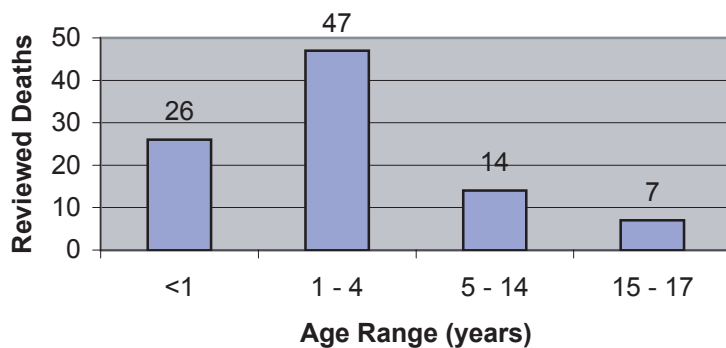


### Findings

- Local Child Fatality Review Committees identified a total of 51 perpetrators in 47 of the deaths (50%)
- Among the identified 51 perpetrators, 63% (32) were the child's natural parent

\* Total = 51, reflecting 4 cases with 2 perpetrators identified

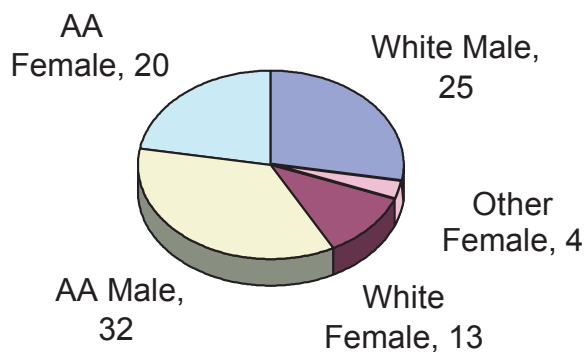
**Figure 10. Age Distribution for Reviewed Deaths with Abuse or Neglect Findings**



#### Findings

- 78% were under the age of 5
- 28% were under the age of 1
- In 2000, there were more cases of infant abuse (42) than of abuse to 1-4 year olds (25) compared to 2001

**Figure 11. Reviewed Deaths with Abuse or Neglect Findings by Race and Gender**



#### Findings

- 55% (52) of deaths were to African American children
- 61% (57) of deaths were to males and 34% (32) were to African American males

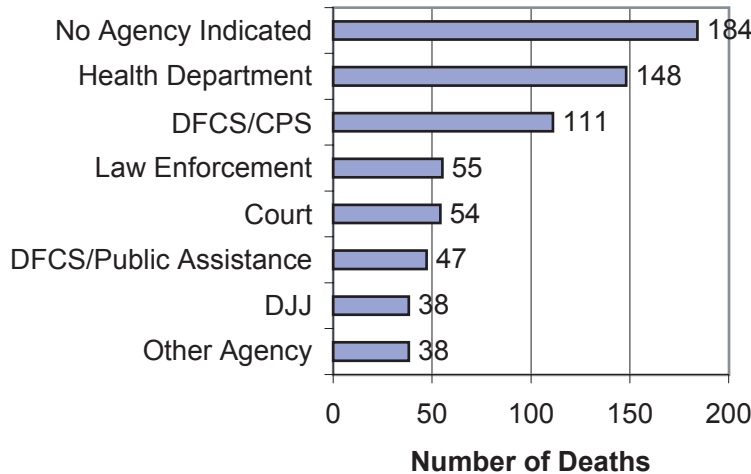
### Opportunities for Prevention

- Promote prevention of child maltreatment as a community endeavor, adhering to proven prevention practices within all sectors of the community
- Expand home-based family support and visitation programs to prevent abuse and neglect
- Adopt a Child Endangerment law that penalizes adults who knowingly place children in dangerous situations and circumstances
- Authorize DFACS to access law enforcement and court records regarding domestic violence in order to better assess the safety of children referred to their care
- Encourage Child Abuse Protocol Committees and Child Fatality Review Committees to take a proactive role in informing communities about prevention needs and successful prevention strategies
- For more information on Child Abuse Prevention please contact Prevent Child Abuse Georgia (800) 532-3208 or [www.preventchildabuse.org](http://www.preventchildabuse.org)

Sixty three percent (336) of all 537 child fatality review reports received for 2001 indicated that one or more community agencies had prior interaction with the deceased child or his/her family. Agencies were not necessarily actively involved with children or families at the time of the deaths. The

following figures list the agencies and the number of deaths in which they were identified. A child or family was often involved with more than one agency; therefore, the number of agency involvements exceed the number of deaths.

**Figure 12. Agency Involvement: Reviewed Deaths with No Child Abuse/Neglect Findings**



## Findings

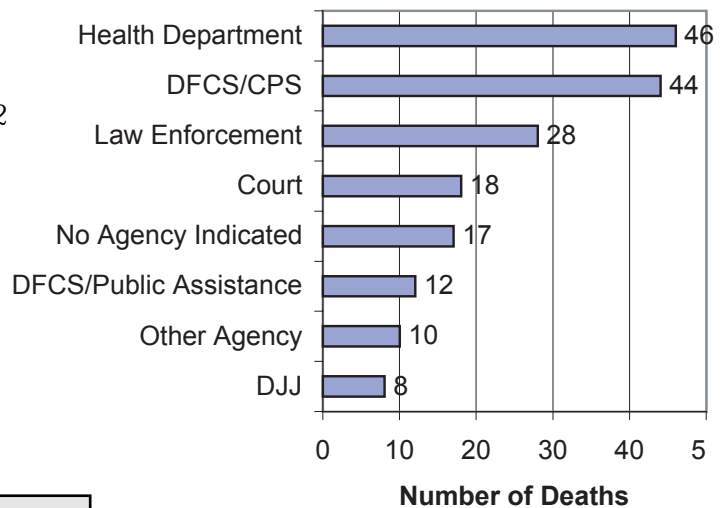
- 58% of deaths (259) with no abuse findings had prior agency involvement
- Families had involvement with an average of 1.9 agencies
- 36% of families had involvement with the Department Family & Children Services
- 33% of families had involvement with Public Health

**Figure 13. Agency Involvement: Reviewed Deaths With Child Abuse/Neglect Findings**

## Findings

- 82% of deaths (77) with abuse findings had prior agency involvement
- Families had involvement with an average 2.2 agencies
- 60% of families had involvement with the Department of Family & Children Services
- 49% of families had involvement with Public Health
- For the 44 children/families known to Child Protective Services, 8 reports did not indicate the nature of the involvement. For the remaining 36 children/families, involvement was as follows:

Decedent	9
Both decedent and another child in the family	11
Another child in the family, not the decedent	10
Decedent, another child in family, and caretaker	3
Caretaker	1
Other child and caretaker	1
Decedent and caretaker	1



# SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age that remains unexplained after completion of 1) an autopsy, 2) a thorough investigation of the death scene, and 3) a review of the clinical history. SIDS is the most common cause of death among normal birth-weight infants between one month and one year of age. It is estimated that at least 3,000 infants within the U.S. die as a result of SIDS each year.

SIDS continued to be a leading cause of infant death in Georgia. In 2001, death certificates listed 116 infant deaths as SIDS. Child fatality review committees reviewed 103 deaths that were determined to be SIDS.

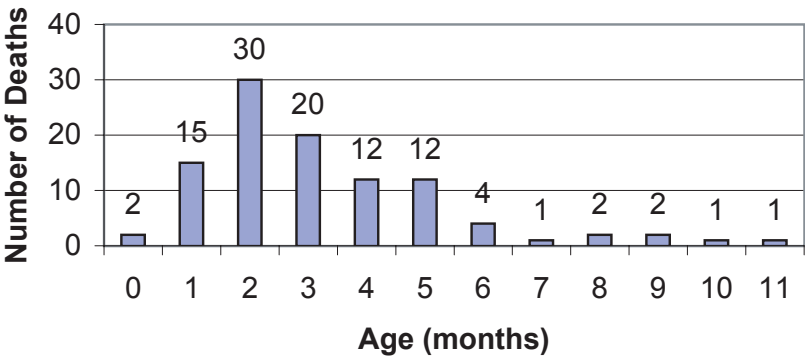
Prior to 1999, SIDS was a “definition by exclusion”, meaning all known causes were to be ruled out before selecting SIDS as a cause of death. However, since the introduction of a new coding system (ICD10) for classifying diseases, SIDS is no longer defined by exclusion of all other causes. Georgia death certificates included 112 deaths with SIDS as

the underlying cause and an additional 6 deaths with SIDS as a secondary cause. For the child fatality review analysis, 4 of the 6 deaths with SIDS as a secondary cause were included in the total SIDS deaths based on additional information obtained in the child fatality review process.

Child fatality review committees reviewed several infant deaths that related to “co-sleeping”. Co-sleeping is a term used to describe an infant sleeping in the same bed with one or more individuals. The coding of SIDS on death certificates appears to acknowledge that co-sleeping (and suffocation of the infant) is a possible cause of death. Twenty Georgia death certificates in 2001 had a combination of SIDS and “suffocation, unknown intent” for the underlying secondary causes of death.

The good news is that the SIDS death rate in Georgia has declined by over 40% since 1990, according to the Office of Infant and Child Health Services of the Division of Public Health.

Figure 14. Reviewed SIDS Death by Age

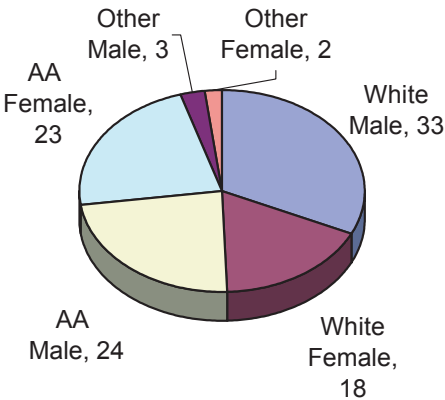


\* 1 death missing DOB and DOD

Finding

- 65% (67) of SIDS deaths occurred among infants 0 to 3 months of age

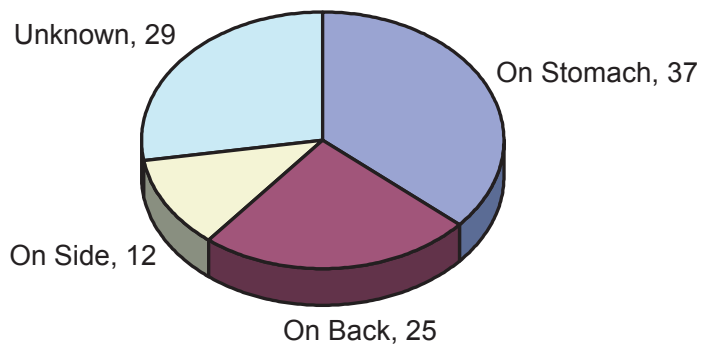
FIGURE 15. Reviewed SIDS Death by Race and Gender



Findings

- 46% (47) of SIDS victims were African American
- 58% (60) of SIDS victims were male

**FIGURE 16. Sleeping Position of Infants Who Died of SIDS**

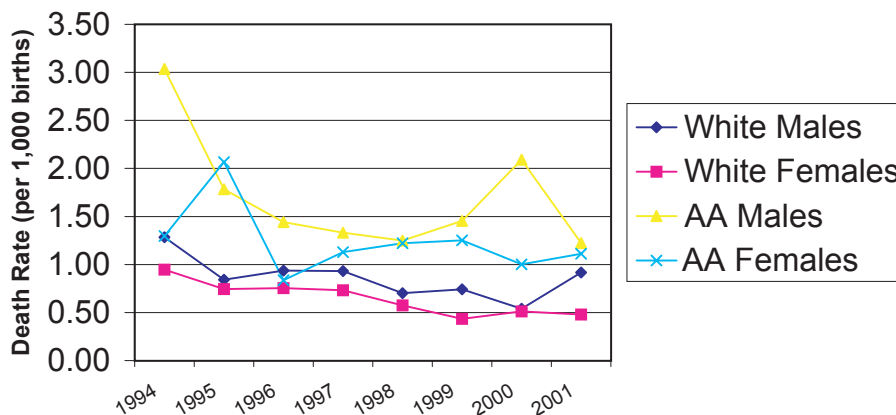


### Findings

- Committees responded to the question regarding sleep position for 102 SIDS deaths. Sleep position was known in 73% (74) of those deaths
- For known sleeping positions, 50% (37) of the victims were reported to be sleeping on their stomachs, and 34% (25) were reported to be sleeping on their backs

## SIDS TRENDS

**Figure 17. SIDS Deaths Rates Per 1,000, Age <1, 1994-2001**



### Findings

- There has been little apparent change in the rate of infant deaths due to SIDS over the past six years. The striking decrease that occurred in the early '90s (and has been attributed to the "Back to Sleep" message) has not continued
- The annual number of infant deaths in Georgia attributed to SIDS has averaged 110 for the past six years. The current death rate (approximately .85 per 1000 births) is less than half the rate during the early '90s
- Male infants are about 50% more likely to die due to SIDS than female infants, and African Americans are about twice as likely as white infants to die due to SIDS

### Opportunities for Prevention

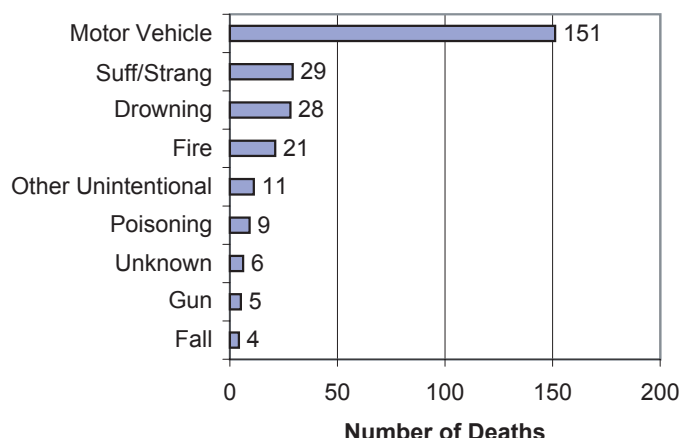
- Educate the public (targeting African American communities) about risk reduction including back sleeping, breastfeeding, prenatal smoking cessation, smoke free environment and use of firm bedding materials
- Incorporate risk reduction information in prenatal education for expectant parents
- Promote a statewide public education program on the risks of overlay when bed-sharing
- For more information on SIDS, contact Georgia DHR Office of Infant and Child Health at (404) 657-4143 or SIDS Alliance (National) 1-800-221-SIDS (7437)

## UNINTENTIONAL INJURY RELATED DEATHS

According to death certificate data, injuries were responsible for 477 child deaths. Three hundred seventy-two (372) of those deaths were unintentional. Child fatality review committees reviewed 264

injury-related deaths determined to be unintentional. Figure 18 shows the distribution of those deaths by type of injury. Committees could not determine the manner of death in 6 instances.

**Figure 18. Reviewed Unintentional Injury-Related Deaths by Cause**



### Findings

- 57% (151) of deaths resulted from motor vehicle-related incidents
- 36% (96) of injury-related deaths occurred among children under the age of 5

## MOTOR VEHICLE-RELATED DEATHS

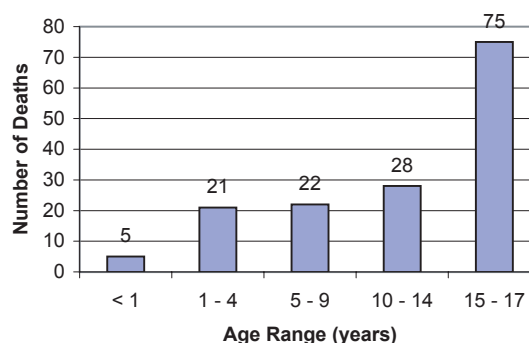
Nationally, motor vehicle crashes remain the leading cause of unintentional injury-related deaths for children 1-14 years old. Twenty-five percent of those children killed between the ages of 5 and 9 were pedestrians. Two out of five deaths among U.S. teens are the result of motor vehicle crashes.

In Georgia, motor vehicle incidents continue to be the leading cause of death among teens 15-17 and the leading cause of unintentional injury-related deaths to children between ages 1-17. Death certificate data indicated that 224 child deaths resulted from motor vehicle incidents. Child fatality review committees reviewed 151 child deaths that were related to motor vehicle incidents.

Of the 151 reviewed motor vehicle-related deaths, 72 (48%) involved children who were passengers, and 34 (22%) were operators of cars, trucks, SUVs, or vans. Information on the presence of restraints was provided for 77 of the reviewed deaths. It was determined that restraints were not used in 30 (42%) incidents in which a vehicle was known to be equipped with a restraint (71). The remaining 30% of the 151 reviewed motor vehicle-related deaths involved bicycles (2), all terrain vehicles (4), motorcycles (3), tractor trailers (2), other farm

vehicles (1), 1 passenger in an aircraft, and 32 pedestrians. Of the 9 children on bicycles, ATV's, and motorcycles, 4 were not wearing safety helmets.

**FIGURE 19. Reviewed Motor Vehicle-Related Deaths by Age**

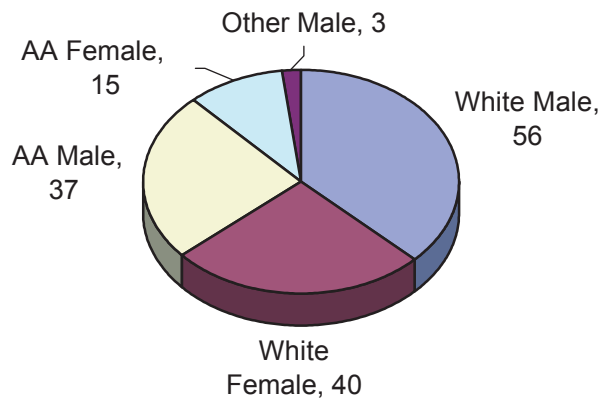


### Findings

- 50% of reviewed motor vehicle-related deaths occurred among teens ages 15-17
- As teens achieved legal driving age, the number of deaths increased as follows:

Age 15	12 deaths
Age 16	32 deaths
Age 17	31 deaths

**Figure 20. Reviewed Motor Vehicle-Related Deaths by Race and Gender**

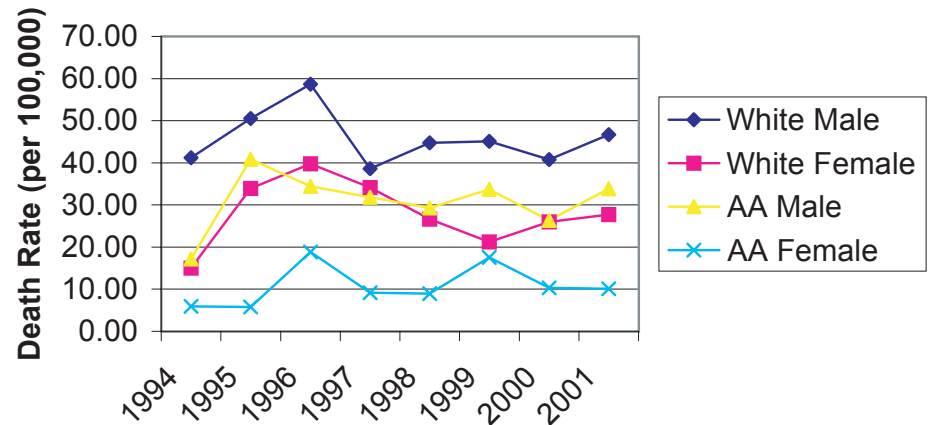


#### Findings

- 64% (96) of deaths were white children
- 64% (96) of deaths were male children

## Motor Vehicle Trends

**Figure 21. Motor Vehicle Fatality Rates per 100,000: Age 15-17, 1994-2001**



#### Findings

- The fatality rate due to motor vehicle crashes among young teens (ages 15-17) has been fairly stable for the past five years. There are approximately 28 deaths per year per 100,000 teens in that age group.
- The motor vehicle death rate is higher among white teens than among African American teens, and the rates among males are higher than among females

#### Opportunities for Prevention

- Enforce the Teenage and Adult Driver Responsibility Act
- Support statewide availability of driver education programs
- Continue to promote bicycle helmet use including education about proper fit and wearing position and establish funding to support community programs that provide helmets to families with young children in need of financial assistance to purchase safety equipment
- Promote educational programs to teach proper installation and use of car seats and proper use of vehicle restraints
- Encourage communities to provide car seats to families with infants and young children who need financial assistance to purchase safety equipment
- Encourage pedestrian safety campaigns
- For more information on prevention of motor vehicle crashes and the proper use of child safety seats & seat belts, please contact the National Highway Traffic Safety Administration, 1-888-DASH-2-DOT or the National Center for Injury Prevention and Control (770) 488-1506 [www.cdc.gov](http://www.cdc.gov)

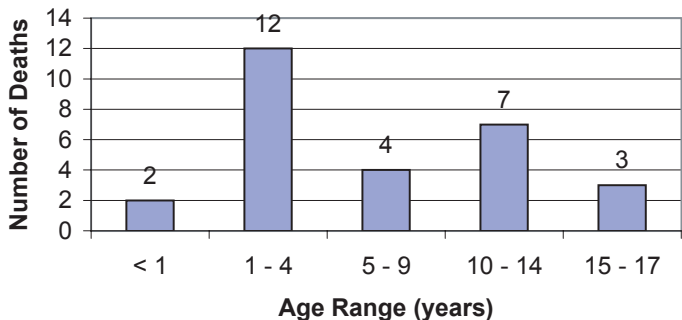
# Drowning

Drowning is the second leading cause of injury-related deaths for children 1 through 14 years of age in the United States. Most children drown in swimming pools at the child’s own home. For the nation as a whole, drowning rates are three times higher in rural areas.

According to death certificate data in Georgia, 40 children died as a result of drowning which was a

15% decrease from 2000. Child fatality review committees reviewed 28 drowning deaths of children under the age of 18 years. Information on the use of floatation devices was provided in 28 reviews which indicated none of the children wore a floatation device. Information regarding supervision was addressed in 26 of the 28 reviewed deaths. Committees determined that in 62% of drowning deaths, supervision was inadequate.

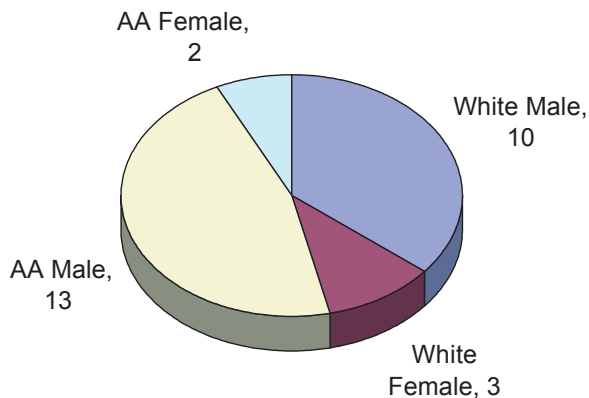
Figure 22. Reviewed Deaths Due to Drowning by Age



## Finding

- 50% of drowning victims were children under the age of 5

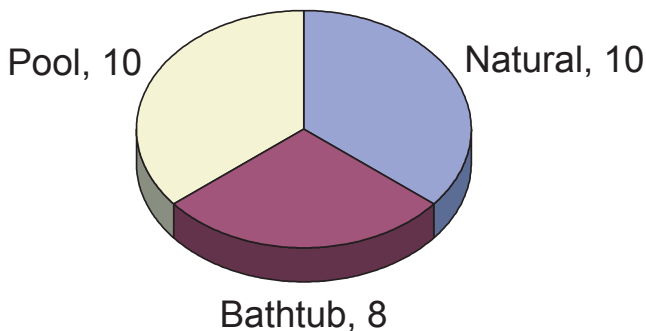
Figure 23. Reviewed Drowning Deaths by Race and Gender



## Finding

- 4.6 times as many drowning deaths occurred among males as females

Figure 24. Place of Drowning

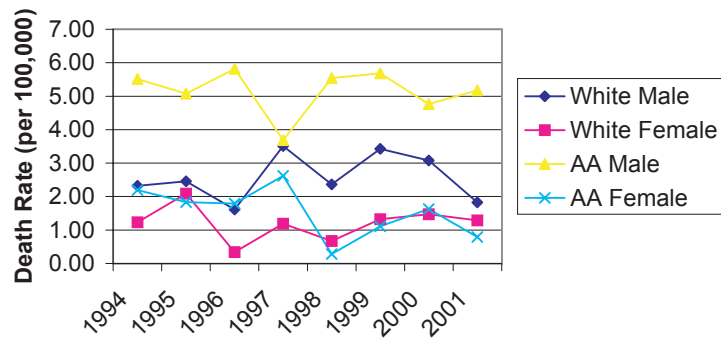


## Findings

- 36% of drowning victims died in a natural body of water
- 36% of drowning victims died in a swimming pool
- The total number of drowning deaths in pools remained the same from 2000 to 2001 (10)
- Drowning deaths in bathtubs increased from 2 in 2000 to 8 in 2001

## Drowning Trends

Figure 25. Drowning Fatality Rates per 100,000: Age < 18, 1994-2001



### Findings

- Over the past eight years, an average of 46 children drowned each year in Georgia
- The number of drowning deaths fluctuates, but there is not any apparent trend
- The rate of drowning deaths among African American males is consistently the highest of all race/sex groups

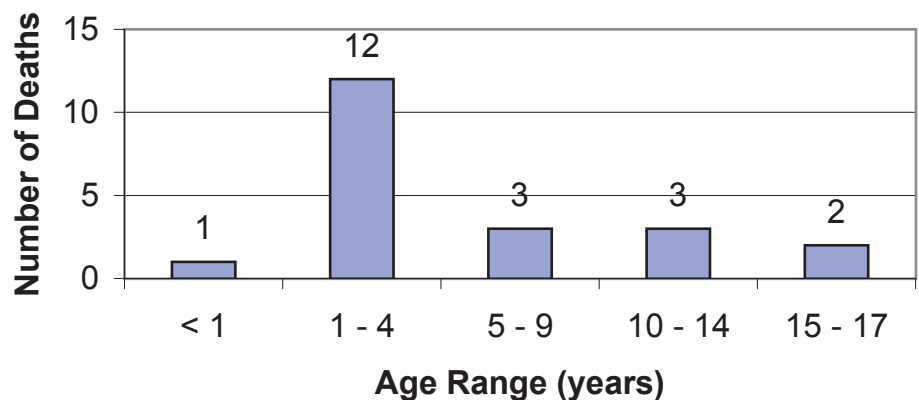
### Opportunities for Prevention

- Increase public education efforts that teach water safety and skills among school age children
- Promote regulations and enforcement to limit alcohol use by operators of recreational boats
- Encourage Department of Natural Resources to establish stronger rescue capabilities at state swimming facilities
- Enact and enforce statewide ordinances related to fences and gates in public and private swimming pools
- For more information on prevention of drowning please contact the National SAFEKIDS Campaign at 202-662-0600 [www.safekids.org](http://www.safekids.org) or American Red Cross (202) 639-3520 [www.redcross.org](http://www.redcross.org)

## Fire /Burn Related Deaths

Residential fires are the most common cause of fire related mortality in the United States. Approximately half of deaths resulting from residential fires occur in homes without smoke alarms. Death certificate data for Georgia indicated a total of 23 fire-related deaths that represent a decrease from 2000 (26). Child fatality review committees reviewed 21 fire/burn related deaths in 2001. Two of those deaths resulted from burns due to hot water scalds.

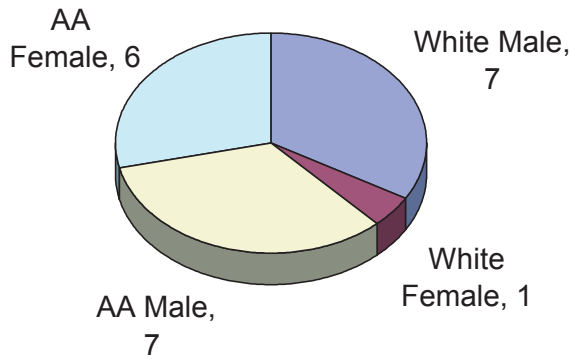
Figure 26. Reviewed Deaths Due to Fire by Age



### Finding

- 76% of victims of fire related deaths were under the age of 10

**Figure 27. Reviewed Deaths Due to Fire by Race and Gender**

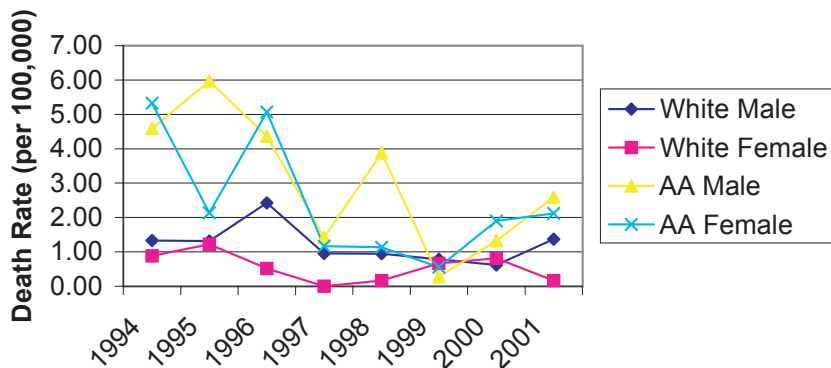


#### Finding

- African American children accounted for 24% more fire-related deaths than White children

## Fire-Related Trends

**Figure 28. Fire-Related Fatality Rates per 100,000 Ages < 18, 1994-2001**



#### Findings

- There have been an average of 30 fire-related deaths per year for the past eight years
- There were an average of 47 deaths per year for 1994-1996, and the number dropped to 20 per year for the past three years (1999-2001)
- African American children are twice as likely to die in fires as White children

## Opportunities for Prevention

- Continue to expand school fire safety programs that teach critical messages like “stop, drop and roll” and those that help families plan fire escape routes
- Continue to expand community programs to provide smoke detectors and batteries to families who cannot afford them
- Promote public education about the importance of changing smoke detector batteries every six months
- For more information on the prevention of fire related deaths and burn prevention, please contact the United States Fire Administration, [www.usfa.gov](http://www.usfa.gov) or the Georgia Firefighters Burn Foundation, (404 320-6223), [www.gfbf.org](http://www.gfbf.org), or SAFE Kids Campaign (203) 662-0600

## INTENTIONAL INJURY DEATHS

The total number of deaths resulting from homicide and suicide (105) for 2001 changed little from 2000 (106), based on death certificate data. In 2001, local Child Fatality Review Committees reviewed a

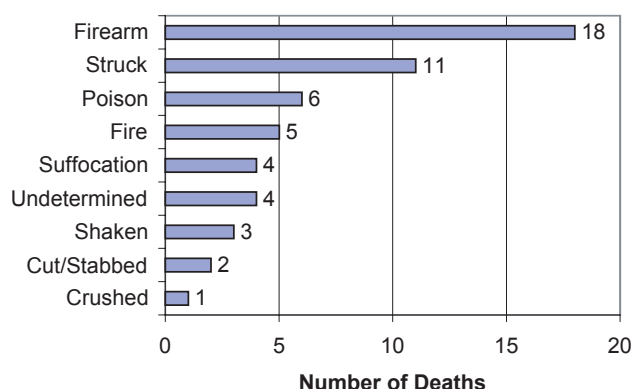
total of 87 deaths (54 homicides and 33 suicides) determined to be the result of intentional injuries. Thirty seven (37) of the 94 reported abuse related deaths were homicides.

### Homicide

Homicide is the second leading cause of death for people ages 10-19 in the United States. Child Fatality Review Committees reported 54 homicide

deaths. The figure below presents reviewed homicide deaths by circumstance of death.

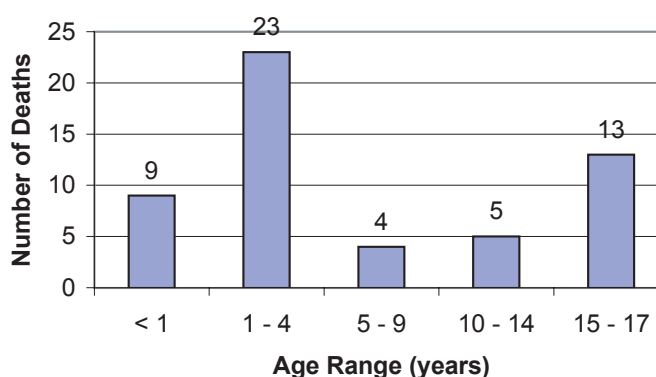
**Figure 29 Reviewed Homicide Deaths by Circumstance of Death**



#### Findings:

- Firearms were the cause of 1/3 of all reviewed homicides
- 24% (13) of homicide deaths were due to injuries resulting from being struck or stabbed
- 11% (6) of homicide deaths were due to poisoning

**Figure 30. Reviewed Homicide Deaths by Age**



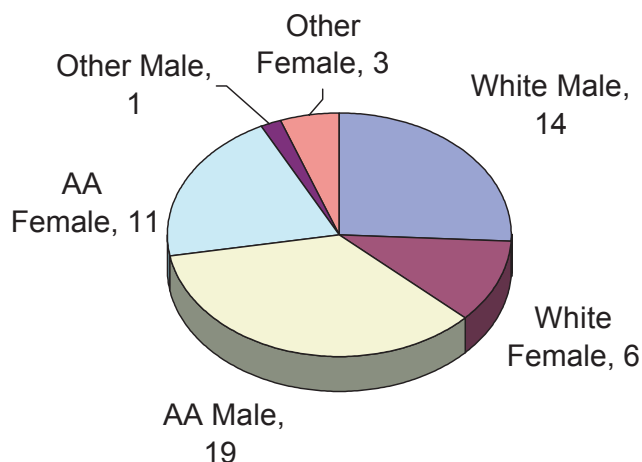
#### Findings:

- Children under 5 years of age represented 59% of all reviewed homicide deaths
- Teenagers ages 15-17 years represented 24% of all reviewed homicides which was a decrease from 2000 (33%)

**Figure 31. Reviewed Homicide Deaths by Race and Gender**

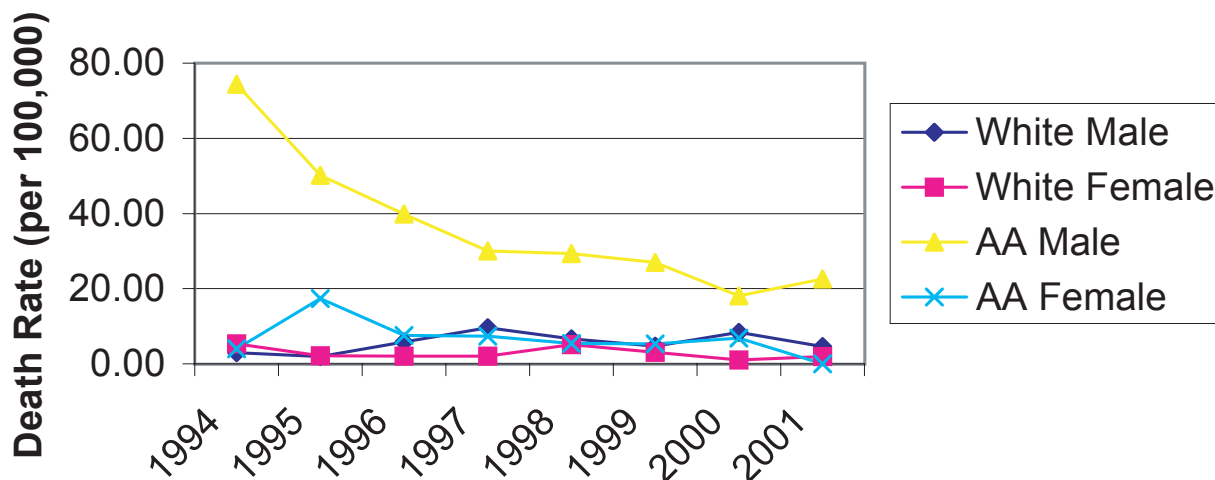
### Findings

- 63% of homicide victims were male
- 56% of homicide victims were African American compared to 47% in 2000



## Homicide Trends

**Figure 32. Death Rates for Teen Homicides per 100,000, Ages 15-17, 1994-2001**



### Findings

- The number of teen homicides (ages 15-17) has decreased continuously during the past 8 years. The average number of deaths per year over a three-year period has dropped from 42 (1994-1996) to 25 (1999-2001), and the rate has decreased from 16 per 100,000 to 6 per 100,000
- Over 60% of all Georgia teen homicide victims were African American males, and their homicide rate over the past three years has been >20 deaths per 100,000

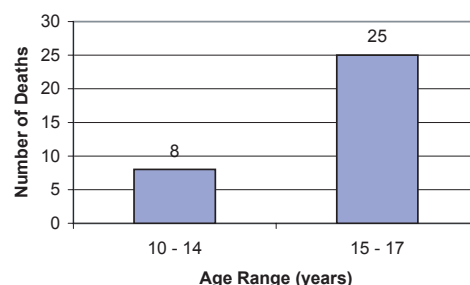
### Opportunities for Prevention

- Promote school and after-school programs teaching conflict resolution, impulse control, anger management and empathy
- Support legislation and public service announcements promoting responsible gun ownership including use of firearm safety locks, safe firearm storage, and warnings to parents and other adults of the dangers to children, and liabilities to parents, of keeping loaded firearms in homes occupied or visited by children
- Support legislation requiring American made guns to be subject to federal safety standards as are other consumer products

In 2001, local Child Fatality Review Committees reviewed 33 deaths of children who took their own lives. Death certificate data indicated a total of 34 suicide deaths which was an increase from 2000 (30). Firearms were used in 42% (14) of reviewed

suicides. Strangulation (hanging) was the circumstance of death for another 16 reviewed deaths. Two deaths resulted from falls, and one death resulted from poisoning.

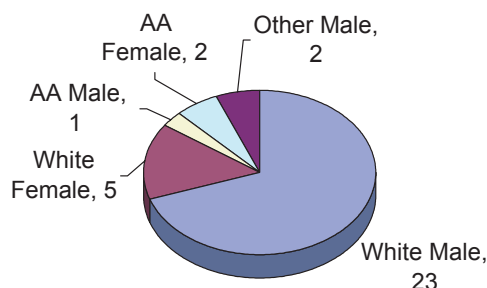
**Figure 33. Reviewed Suicide Deaths by Age**



## Findings

- 76% (25) of reviewed suicide deaths occurred to teens 15-17
- The youngest reviewed suicide victim (11 years old) died of injuries sustained from strangulation due to hanging

**Figure 34. Reviewed Suicide Deaths by Race and Gender**



## Findings

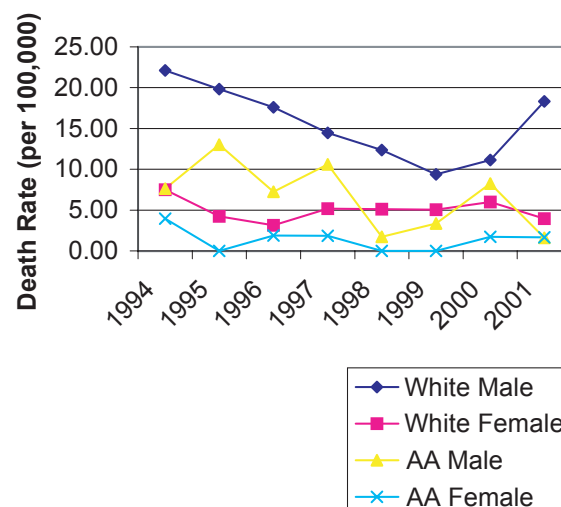
- 85% of all reviewed suicide victims were White children
- 79% of all reviewed suicide victims were males
- 70% of all reviewed suicide victims were White males

## Suicide Trends

**Figure 35. Suicide Death Rates per 100,000, Ages 15-17, 1994-2001**

## Findings

- The average annual number of teen suicides (22) has been lower the past 4 years (1998-2001) than the prior 4 years (31)
- Suicide rates for all 15-17 year olds declined each year from 1994 (11.3) through 1999 (4.94). Rates increased in 2000 (6.84) and again in 2001 (7.55)
- White males comprise over 60% of the suicide victims over the eight-year period, and their suicide death rate has averaged about 13 per 100,000 over the past four years



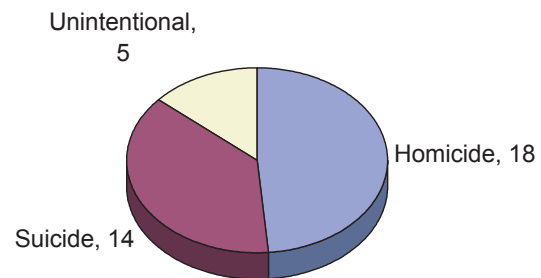
## Opportunities for Prevention

- Increase the access and availability of mental health and substance abuse prevention and treatment services to children and youth
- Increase awareness among parents, caretakers and communities of suicide warning signs, and promote prompt action when warning signs are recognized
- Develop community intervention resources for children at risk of suicide
- Advocate for safe home storage of firearms

## FIREARM DEATHS

Firearm deaths include homicides, suicides, and unintentional injuries. It is estimated that every two hours in the U.S., a child is killed with a loaded gun. Most young homicide victims are killed with firearms. Ninety percent (90%) of unintentional shootings involving children are linked to easy-to-find, loaded handguns in the home. In Georgia, death certificate data indicated a total of 47 deaths caused by firearms. Child Fatality Review Committees reviewed 37 deaths caused by firearms. Child fatality review reports ask for information not available on death certificates, including source of the firearm, type of firearm, who was using the firearm at the time of death, and the age of the firearm handler. This information provides important guidance for prevention.

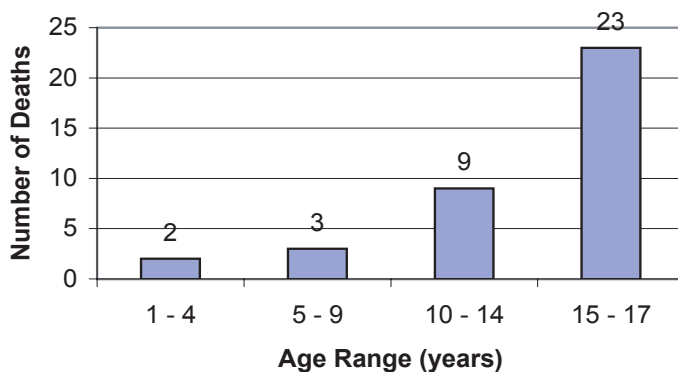
**Figure 36. Reviewed Firearm Deaths by Manner of Death**



### Finding

- 49% of firearm-related deaths were homicides

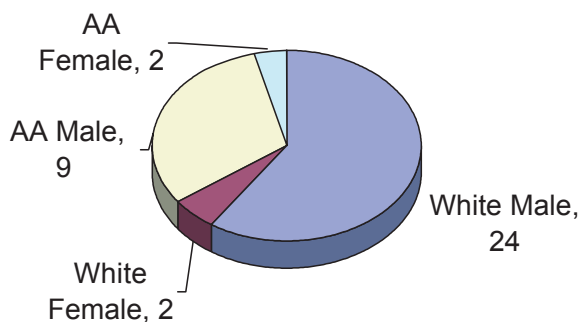
**Figure 37. Reviewed Firearm Related Deaths by Age**



### Findings

- 62% of reviewed firearm deaths occurred to children aged 15- 17
- Of reviewed firearm deaths among 15-17 years olds, 48% (11) were homicides and 43% (10) were suicides

**Figure 38. Reviewed Firearm Deaths by Race and Gender**



### Findings

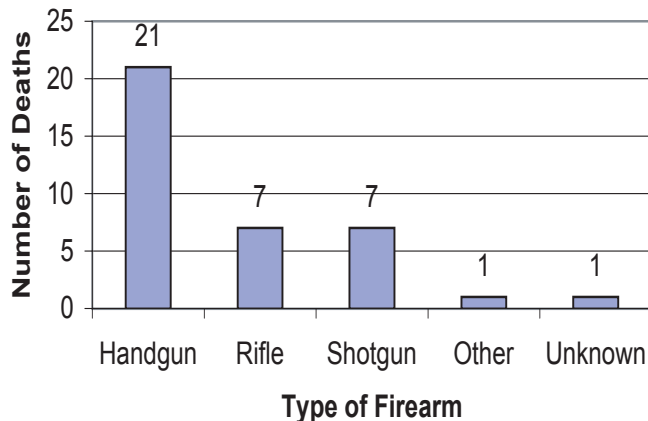
- 70% of reviewed firearm deaths occurred to White children
- 89% of reviewed firearm deaths were males

### Source of Firearm

- In 49% (18) of reviewed firearm deaths, the firearm was obtained from someone the child knew (a parent, other relative or acquaintance)
- Parents were the source of the firearm in 50% (7 of the 14) of reviewed suicides by firearm
- The source of the firearm was unknown in 51% (19) of reviewed firearm related deaths

## Type of Firearm

**Figure 39. Reviewed Firearm Deaths by Type of Firearm**



### Findings

- 57% (21) of the firearms were handguns compared to 66% in 2000
- 19% (7) of the firearms were shotguns compared to 5% (2) in 2000
- 14 of the 33 reviewed suicide deaths were committed with a firearm:
  - 6 (43%) = handgun
  - 4 = shotgun
  - 3 = rifle
  - 1 = other type
- Of the 54 reviewed homicides, 33% (18) were committed with a firearm:
  - 14 (78%) = handgun
  - 2 = shotgun
  - 1 = rifle
  - 1 = firearm type unknown

### Usage

- In 76% of firearm deaths (28) the shooter was aiming at himself or at someone else
- Three deaths were the result of the shooter "playing" with the firearm

### Storage

- Storage of the firearm was only indicated in 7 of the 37 reviewed firearm deaths
- Of the 7 cases in which storage location was known, 6 indicated the firearm had not been secured to prevent use by children or unauthorized adults

### Age of Handler

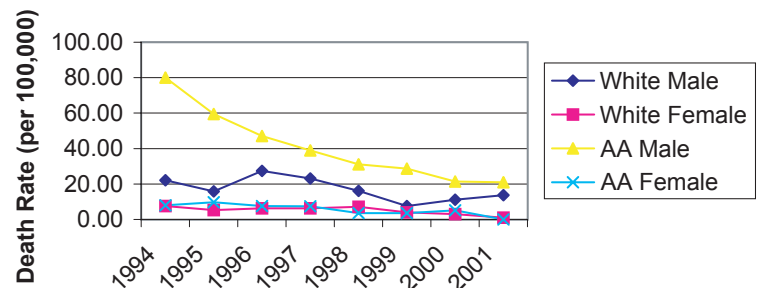
- The shooter was under the age of 15 in 3 of 5 unintentional deaths
- The shooter was 15 or over in 66% (21) of all intentional deaths

## Firearm Trends

### Findings

- All deaths attributed to firearms have declined over the eight-year period. The average annual number of deaths was 67 for 1994-1996, and dropped to 31 for 1999 to 2001
- However, most of the decline in firearm deaths has been in the African American male population. The firearm death rate in this population has declined from a high of 80 per 100,000 in 1994 to about 21 per 100,000 in 2000 and 2001

**Figure 40. Firearm Death Rates per 100,000, Ages 15-17, 1994-2001**



### Opportunities for Prevention

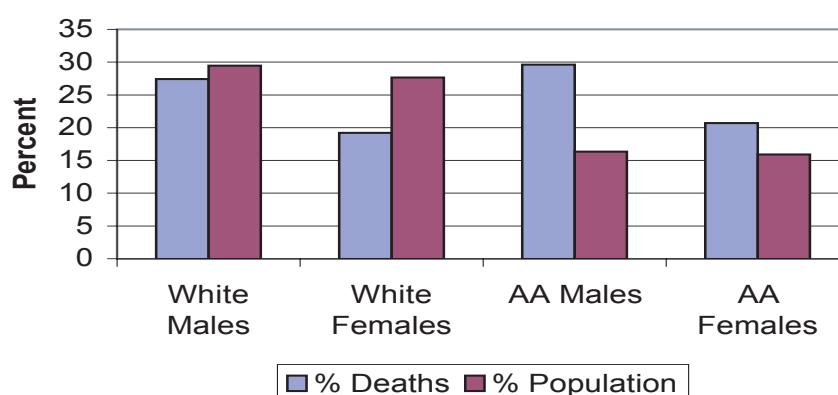
- Promote school and community-based risk reduction and firearm safety programs for children, parents and other caretakers
- Promote the use of firearm safety devices, including trigger locks
- Support efforts to limit minors' access to firearms

## RACE, ETHNICITY AND DISPROPORTIONATE DEATHS

Data are presented in this report by race and gender for each type of death to enable more detailed analysis. The terms “White”, “African-American” (A-A) and “Other” are used to identify racial groups throughout the report. “Other” refers to children of Asian, Pacific Islander, or Native

American origin. Death certificate data includes ethnicity information that can identify children of Hispanic origin. Ninety-one (91) of 95 deaths identified as Hispanic indicated the race as “White.” The 4 remaining deaths identified as Hispanic indicated the race to be “Other”.

**Figure 41. Deaths to Children < 1 and Percent of Population in Georgia By Race and Gender**



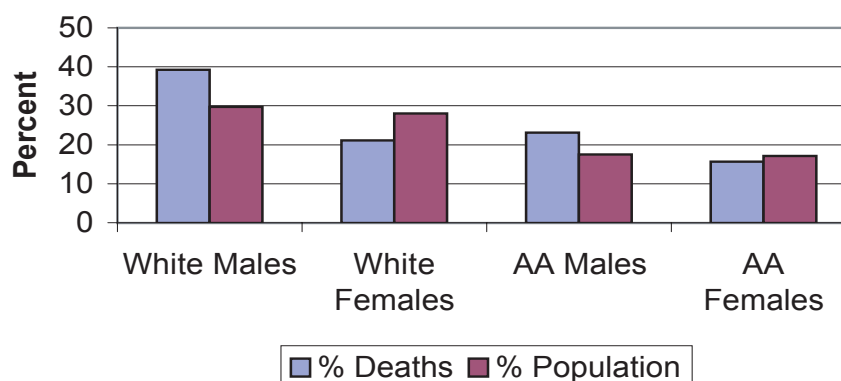
### Findings

- A disproportionate number of deaths occurred among African-American infants

	% of Deaths	% of Population
All A-A Infants	50.3	32.3
A-A-Male Infants	29.6	16.3
A-A Female Infants	20.7	15.9

- The infant mortality rate for African-American infants (13.5 per 1,000 births) was more than double the rate for white infants (6.2 deaths per 1,000 births)

**Figure 42. Deaths to Children 1-17 and Percent of Population in Georgia, By Race and Gender**



### Findings

- A disproportionate number of deaths occurred among male children
- Males between the ages of 1 and 17 are about 50% more likely to die than females in the same age range

	% of Deaths	% of Population
All Males 1–17	62.9	51.3
AA-Males 1–17	23.1	17.5
White Males 1-17	39.2	29.7

# THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

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## 1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adopted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Change the name of the Statewide Child Fatality Review Panel to the Statewide Child Abuse Prevention Panel and require the Panel to:
- Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
- Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
- Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases
- Monitor implementation of the State Child Abuse Prevention Plan

## 1996 - 1998

- The Statewide Child Abuse Prevention Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- An evaluation of the child fatality review process was conducted by researchers from Emory University and Georgia State University. The

evaluation concluded that there were policy, procedure, and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly

- Statutory amendments were adopted to:
  - Identify agencies required to be represented on child fatality review teams, and establish penalties for non-participation
  - Require that all child deaths be reported to the coroner/medical examiner in each county
  - Establish additional requirements for county child fatality review committees

## 1999 - 2002

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Team members were identified as law enforcement, coroner or medical examiner, district attorney representative, and department of family and children services representative. Teams assumed responsibility for conducting death scene investigations of child deaths within their judicial circuit that met established criteria
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. The name of the Statewide Child Abuse Prevention Panel was changed to the Georgia Child Fatality Review Panel
- The Panel's budget was increased to allow for 2 additional staff persons, and establishment of physical office space.
- Funding was secured to purchase an on-line reporting system

## APPENDIX A

### CRITERIA FOR CHILD DEATH REVIEWS

Child Fatality Review Teams are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

#### **“Eligible” Deaths or Deaths to be Reviewed by Child Fatality Review Teams O.C.G.A. 19-15-3(e)**

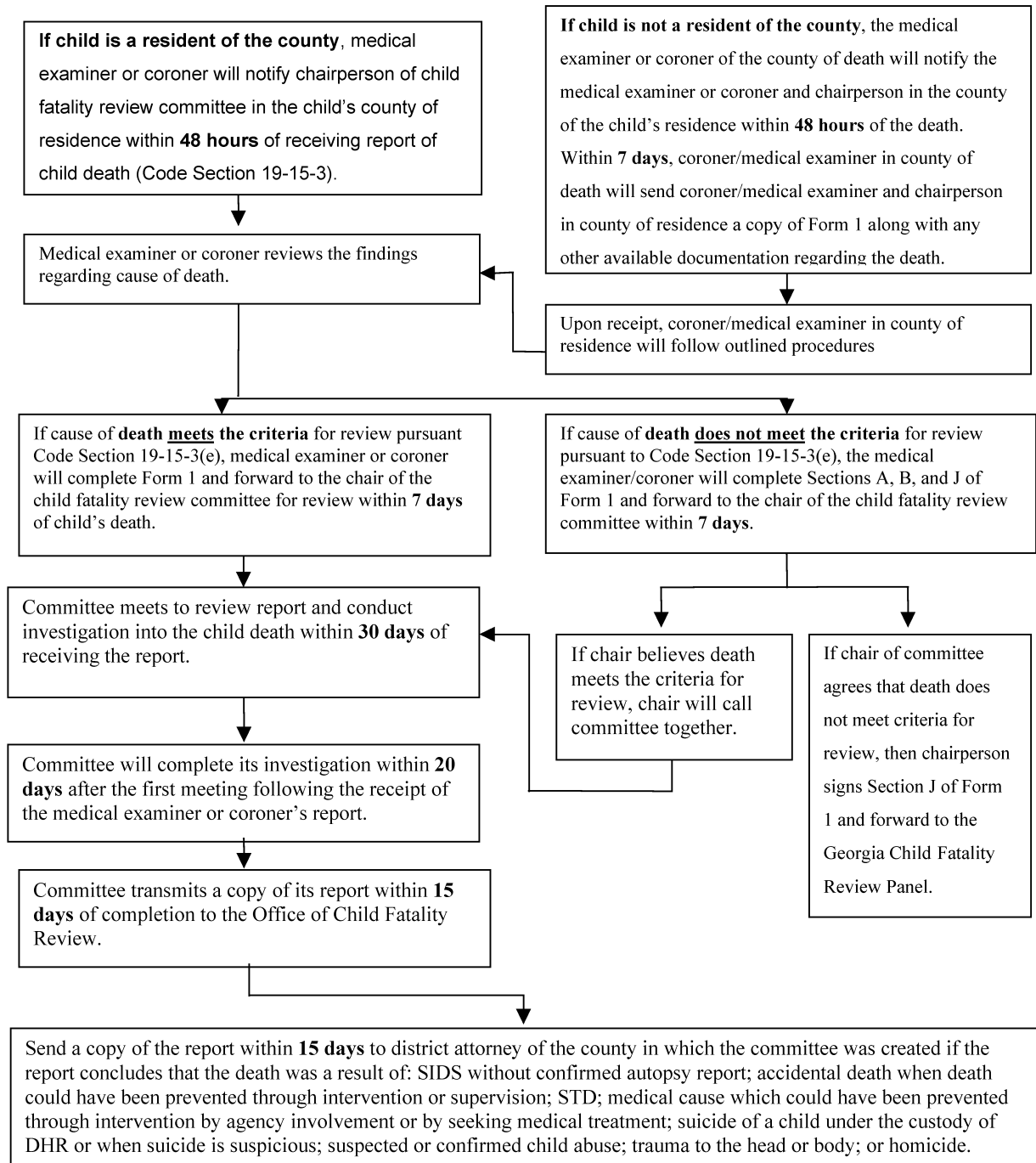
The death of a child under the age of 18 must be reviewed when the death is *suspicious, unusual, or unexpected*. Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e., car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

## APPENDIX B

### CHILD FATALITY REVIEW TIMEFRAMES AND RESPONSIBILITIES

#### CHILD FATALITY REVIEW TEAM TIMEFRAMES AND RESPONSIBILITIES



## APPENDIX C.1 Total Child Fatalities Based on Death Certificate

Infant (Age < 1)	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	1			1			2
	Fire / Burns	1	1					2
	Homicide	1	1	5	3			10
	Medical Causes	257	184	292	197	18	15	963
	Other Accident	1	2	2	1			6
	Poisoning	1		2				3
	SIDS	39	22	28	26	1		116
	Suffocation	8	2	5	2		1	18
	Unknown	3	5	3	4			15
	Vehicle Accident	1	2	1	2			6
	Total	313	219	338	236	19	16	1141

Infant (Ages 1 to 4)	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	6	6	4				16
	Fire / Burns	5		2	6			13
	Homicide	8	4	6	10			28
	Medical Causes	37	17	22	14	1	1	92
	Other Accident	6	1		1		1	9
	Poisoning	1			1			2
	Suffocation		1	3	2			6
	Unknown	1		1	1			3
	Vehicle Accident	14	11	6	3			34
	Total	78	40	44	38	1	2	203

Infant (Ages 5 to 14)	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	1	1	11	1			14
	Fire / Burns	2		3	1			6
	Homicide	5	4	3	1			13
	Medical Causes	35	23	14	34			106
	Other Accident	5		1				6
	Suffocation	2	3	2				7
	Suicide	4	1		1	1		7
	Vehicle Accident	25	21	20	11			77
	Total	79	53	54	49	1		236

Infant (Ages 15 to 17)	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	4	1	2	1			8
	Fire / Burns			2				2
	Homicide	4	2	14				20
	Medical Causes	13	10	14	8			45
	Other Accident	3						3
	Poisoning	5						5
	Suicide	20	4	1	1	1		27
	Unknown	1	1					2
	Vehicle Accident	51	28	21	6	1		107
	Total	101	46	54	16	2		219

## APPENDIX C.2 Total Reviewed Child Fatalities 2001

Infant (Age < 1)	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	1			1			2
	Fall			2	1			3
	Fire / Burns		1					1
	Homicide	1		4	3		1	9
	Medical Causes	7		12	18	2	1	40
	Other Accident		1					1
	Poisoning	1		1				2
	SIDS	33	18	24	23	3	2	103
	Suffocation	5	1	6	1	1	2	16
	Unknown			2	1			3
	Vehicle Accident	1	2	1	1			5
	Total	49	23	52	49	6	6	185
Ages 1 to 4	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	6	2	4				12
	Fall	1						1
	Fire / Burns	5		2	5			12
	Firearm	1						1
	Homicide	7	3	5	7		1	23
	Medical Causes	6	4	4	1	2		17
	Other Accident	3	1		1		1	6
	Poisoning	1			1			2
	Suffocation	1		3	2			6
	Unknown	1			1			2
	Vehicle Accident	7	7	5		2		21
	Total	39	17	23	18	4	2	103
Ages 5 to 14	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	1	1	8	1			11
	Fire / Burns	2		3	1			6
	Firearm	2						2
	Homicide	3	3	1	1		1	9
	Medical Causes	7	3	4	7			21
	Other Accident	2		1				3
	Suffocation	1	3	3				7
	Suicide	5	1		1	1		8
	Vehicle Accident	16	12	13	8	1		50
	Total	39	23	33	19	2	1	117
Ages 15 to 17	Cause of Death	White		Black		Other		Total
		Male	Female	Male	Female	Male	Female	
	Drowning	2		1				3
	Fire / Burns			2				2
	Firearm	2						2
	Homicide	3		9		1		13
	Medical Causes	1	1	2	1			5
	Other Accident	1						1
	Poisoning	5						5
	Suicide	18	4	1	1	1		25
	Unknown	1						1
	Vehicle Accident	32	19	18	6			75
	Total	65	24	33	8	2		132

## APPENDIX C.3 Reviewed Child Fatalities with Abuse Findings 2001

Infant (Age < 1)	Cause of Death	White		Black		Other	Total
		Male	Female	Male	Female	Female	
	Drowning				1		1
	Fire / Burns		1				1
	Homicide	1		4	2	1	8
	Medical Causes			1	1		2
	Poisoning	1		1			2
	SIDS		2	4	1		7
	Suffocation	1		2		1	4
	Unknown			1			1
	Total	3	3	13	5	2	26

Ages 1 to 4	Cause of Death	White		Black		Other	Total
		Male	Female	Male	Female	Female	
	Other Accident	1			1	1	3
	Drowning	1	1	4			6
	Fall	1					1
	Fire / Burns	3		1	1		5
	Homicide	6	2	5	7	1	21
	Vehicle Accident	1	2	2			5
	Poisoning	1			1		2
	Suffocation			1	1		2
	Unknown	1			1		2
	Total	15	5	13	12	2	47

Ages 5 to 14	Cause of Death	White		Black		Other	Total
		Male	Female	Male	Female	Female	
	Drowning			3			3
	Fire / Burns				1		1
	Homicide	2	3				5
	Vehicle Accident	1	1		1		3
	Suffocation		1				1
	Suicide	1					1
	Total	4	5	3	2		14

Ages 15 to 17	Cause of Death	White		Black		Other	Total
		Male	Female	Male	Female	Female	
	Homicide			3			3
	Medical Causes				1		1
	Vehicle Accident	1					1
	Suicide	2					2
	Total	3		3	1		7

## APPENDIX C.4 Prevention Potential of Reviewed Child Fatalities by Abuse Classification and Cause of Death

### Confirmed Abuse

Cause of Death	Prevention Finding				Total
	Missing	Not Preventable	Possibly	Definitely	
Medical			1	1	2
SIDS				1	1
Homicide		3	2	26	31
Vehicle Crashes				4	4
All Other Acc.		1	1	18	20
Total		4	4	50	58

Suspected (but not confirmed) Abuse

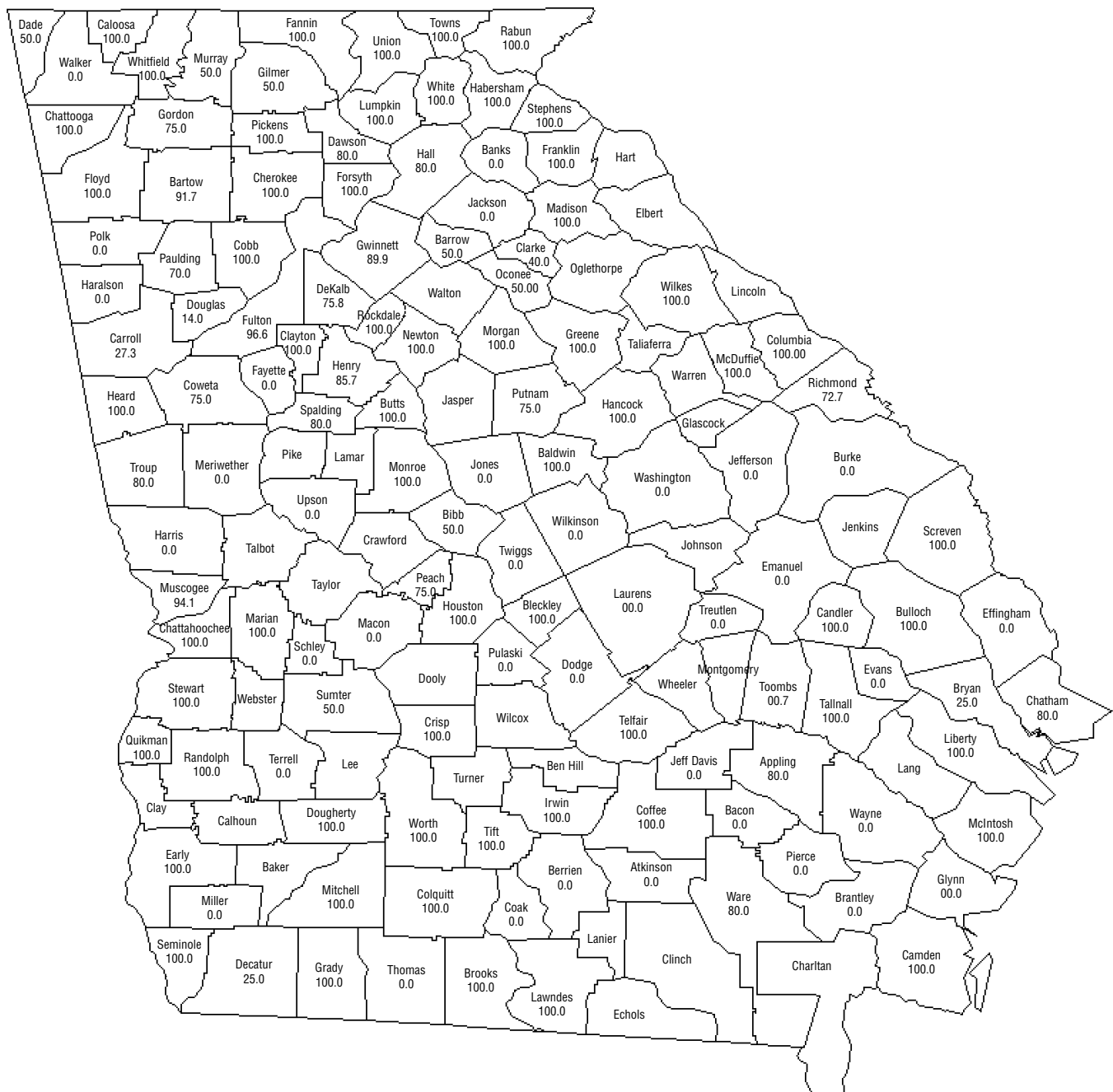
Cause of Death	Prevention Finding				Total
	Missing	Not Preventable	Possibly	Definitely	
Medical			1		1
SIDS			6		6
Homicide			2	4	6
Suicide			1	2	3
Vehicle Crashes			3	2	5
All Other Acc.			6	9	15
Total			19	17	36

No Abuse Finding

Cause of Death	Prevention Finding				Total
	Missing	Not Preventable	Possibly	Definitely	
Medical	1	58	18	3	80
SIDS	2	33	58	3	96
Homicide		1	4	12	17
Suicide		4	14	11	29
Vehicle Crashes	2	16	53	71	142
All Other Acc.	2	4	32	41	79
Total	7	116	179	141	443

## Percent of Reviewable Deaths Reviewed, 2001, by County

Note: Counties without a percent had no reviewable deaths for 2001



## APPENDIX E

### 2001 CHILD FATALITY REVIEWS, BY COUNTY, BY AGE GROUPS

Appendix E presents county level data for the Child Fatality Review process in 2001. The data is presented for four age groups (infants less than 1 year old, children from 1 to 4 years of age, children 5 through 14, and teenagers ages 15 through 17). Four numbers are provided for each age group:

**Total Deaths:** The total number of deaths (all causes) for that age group. This number is based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia.

**Eligible Deaths:** The number of SIDS, unintentional, or violence-related deaths (eligible deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and unintentional/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH).

**Eligible Deaths Reviewed:** The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "eligible" deaths.

**Total Deaths Reviewed:** This is the total number of child deaths in 2001 for which a Child Fatality Review Report was submitted. It includes deaths due to medical causes (other than SIDS) in addition to those deaths which were identified as eligible for review. This is based on the county of residence identified from the death certificate.

# Appendix E

## Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					15-17 Total	"Reviewable" Deaths					15-17 Total	"Reviewable" Deaths Reviewed					15-17 Total	Total Deaths Reviewed					15-17 Total
	AGE	<1	1-4	5-14	15-17		<1	1-4	5-14	15-17	<1		1-4	5-14	15-17	<1	1-4		5-14	15-17	<1	1-4	5-14	
Appling		5	3	3		11	1	2	2		5	1	2	1		4		3	1		4			
Atkinson		3	1	1		5	1	1	0		2					0					0			
Bacon			1	2		3			2		2					0					0			
Baker						0					0					0					0			
Baldwin		11	2	2	2	17	1		2	1	4	1		2	1	4	2	1	2	1	6			
Banks			1	1		2			1	1	2					0					0			
Barrow		4		1	1	6	2		1	1	4	1		1		2		1	1		2			
Bartow		8	4	1	5	18	5	1	1	5	12	5	1	1	4	11	5	2	1	5	13			
Ben Hill		2		1		3					0					0					0			
Berrien		2		0	1	3			0	1	1					0					0			
Bibb		36	3	9	7	55	3		6	6	15	2		4	2	8	3	3	2		8			
Bleckley		1		0	1	2			0	1	1			0	1	1	1		0	1	2			
Brantley		1		0	1	2			0	1	1					0					0			
Brooks				1	1	2			1	1	2			1	1	2		1	1	1	2			
Bryan		1	1	1	2	5			1	1	2			1		1			1		1			
Bulloch		6	1	1	3	11			1	1	2			1	1	2	4	1	1	2	4			
Burke		1	1	1		3			1	0	1					0					0			
Butts		3		0	3	6	1		0	3	4	1		0	3	4	1		0	3	4			
Calhoun		1		0		1					0					0	1		0		1			
Camden		5	1	0	1	7			0	1	1			0	1	1	1		0	1	2			
Candler		3		2		5			2		2			2		2		2			2			
Carroll		9	6	3	6	24	1	4	0	6	11	1		0	2	3	2	1	0	2	5			
Catoosa		6	1	0	1	8			1	0	1			1	0	1	2		1	0	1	2		
Charlton		3		0		3					0					0					0			
Chatham		40	3	7	1	51	6		5	1	12	6		4		10	7		6		13			
Chattahoochee		3		0		3	1		0		1	1		0		1	1		0		1			
Chattooga		2	1	0		3	1	1	0		2	1	1	0		2	1	1	0		2			
Cherokee		8	2	3	5	18	1	1	1	4	7	1	1	1	4	7	1	1	1	4	7			
Clarke		9	2	4	3	18	1		1	3	5	1		0	1	2	3		0	1	4			
Clay						0					0					0					0			
Clayton		35	3	8	6	52	4	2	2	3	11	4	2	2	3	11	5	3	4	3	15			
Clinch						0					0					0					0			
Cobb		84	14	11	11	120	5	9	4	6	24	5	9	4	6	24	8	12	6	6	32			

## Appendix E

### Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					“Reviewable” Deaths					“Reviewable” Deaths Reviewed					Total Deaths Reviewed					
	AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Coffee		7	1	2	3	13	2		1	3	6	2		1	3	6	2		1	3	6
Colquitt		4	2	1	3	10	1		1	1	3	1		1	1	3	2		1	1	4
Columbia		4	1	4	3	12			2	3	5			2	3	5	2		2	2	7
Cook		2	1	0		3	1		1	0	2					0					0
Coweta		6		4		10	1			3	4			3		3			3		3
Crawford		2		0		2					0					0					0
Crisp		6	2	2	1	11	1		1	1	4	1		1	1	4	1		2	2	6
Dade		2	1	0	2	5			0	2	2			0	1	1			1		1
Dawson		3		0	3	6	2		0	3	5	1		0	3	4	1		0	3	4
Decatur		6		3		9	2		2		4	1		0		1					0
DeKalb		90	10	14	15	129	11	6	6	10	33	10	3	3	9	25	16	6	7	9	38
Dodge		4	2	1	2	9			1	2	3					0					0
Dooly		4		0		4					0					0					0
Dougherty		19	5	0		24	2	2	0		4	2	2	0		4	4	1	0		5
Douglas		14	1	4		19	3	1	3		7		1	0		1					0
Early		3	1	0		4	1		0		1	1		0		1	1	1	0		2
Echols						0					0					0					0
Effingham		3	1	2	1	7		1	1	1	3					0					0
Elbert						0					0					0					0
Emanuel		4	4	2	1	11	1	4	0	1	6					0					0
Evans		3	1	0		4	1	1	0		2					0					0
Fannin		3		1	1	5	2		0	1	3	2		0	1	3	2		0	1	3
Fayette		3	6	3	3	15		2	2	3	7					0					0
Floyd		11	2	0	3	16	5	2	0	3	10	5	2	0	3	10	5	2	0	3	10
Forsyth		10	2	3		15	4	1	2		7	4	1	2		7	4	1	3		8
Franklin		3		2	1	6	1		2	1	4	1		2	1	4	1		3	1	5
Fulton		99	15	22	21	157	23	13	8	15	59	22	12	8	15	57	28	13	13	19	73
Gilmer		1		0	2	3			0	2	2			0	1	1			0	1	1
Glascok		1		0		1					0					0					0
Glynn		16	1	1	2	20	3		0	2	5	2		0	1	3	2		0	1	3
Gordon		3	1	1	1	6	1	1	1	1	4		1	1	1	3		1	1	1	3
Grady		4	1	1	2	8	1	1	1		3	1	1	1		3	2	1	1		4
Greene		1	1	1	1	4			1	1	1			1	1	1			1	1	1

# Appendix E

## Child Fatality Reviews, by Death Certificate County of Residence

County AGE	Total Deaths					“Reviewable” Deaths					“Reviewable” Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Gwinnett	70	15	15	10	110	4	10	4	9	27	3	10	4	7	24	3	9	4	7	23
Habersham	4	1	0	5	5	2	1	0	3	3	2	1	0	3	3	2	1	0	3	3
Hall	29	4	4	4	41	5	1	0	4	10	3	1	0	4	8	3	1	1	4	9
Hancock	1	1	1	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Haralson	6	0	3	9	9	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0
Harris	2	1	1	1	5	1	1	1	2	2	0	0	0	0	0	0	0	0	0	0
Hart	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Heard	4	0	0	4	4	2	0	0	2	2	2	0	0	2	2	2	0	0	2	2
Henry	18	1	6	2	27	5	2	7	7	7	4	2	6	6	6	1	2	4	2	9
Houston	19	2	3	1	25	1	2	3	1	7	1	2	3	1	7	1	2	4	1	8
Irwin	3	0	0	3	3	2	0	0	2	2	2	0	0	2	2	2	0	0	2	2
Jackson	7	2	0	1	10	2	1	0	3	3	0	0	0	0	0	0	0	0	0	0
Jasper	1	1	1	2	2	0	0	0	0	0	0	0	0	0	0	1	1	1	2	2
Jeff Davis	3	1	1	4	4	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0
Jefferson	4	1	1	6	6	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jones	2	1	1	1	5	1	0	1	2	2	0	0	0	0	0	0	0	0	0	0
Lamar	2	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	5	1	1	1	8	2	1	1	3	3	1	1	1	1	1	1	1	2	3	3
Lee	1	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Liberty	11	5	1	17	17	1	3	1	5	5	1	3	1	5	5	2	3	1	6	6
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Long	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	24	1	2	6	33	3	1	4	8	8	3	1	4	8	8	4	1	1	5	11
Lumpkin	1	2	0	3	3	1	0	1	1	1	1	0	1	1	1	1	1	0	1	1
Macon	1	1	2	4	4	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0
Madison	2	1	1	1	5	1	1	1	3	3	1	1	1	3	3	1	1	1	1	3
Marion	1	1	0	2	2	1	0	1	1	1	1	0	1	1	1	1	1	0	1	1
McDuffie	8	0	0	2	10	2	0	1	3	3	2	0	1	3	3	1	0	1	2	2
McIntosh	1	0	1	2	2	0	0	1	1	1	0	0	1	1	1	0	1	0	1	1
Meriwether	2	2	0	4	4	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0

Appendix E  
Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					“Reviewable” Deaths					“Reviewable” Deaths Reviewed					Total Deaths Reviewed				
	AGE	<1	1-4	5-14	15-17 Total	<1	1-4	5-14	15-17 Total	<1	1-4	5-14	15-17 Total	<1	1-4	5-14	15-17 Total			
Miller			1	0	1		1	0	1				0				0			
Mitchell		4	2	0	6		1	1	2		1	1	0		2	2	0			
Monroe		6	0	0	1	7	1	0	1	2	1	0	1	2	1	0	1			
Montgomery		1	0	0	1				0				0				0			
Morgan		2	1	0	1	4		1	0	1	2	1	0	1	2	1	0			
Murray		6	2	2	8		2	2	4		1	1	1	2	1	1	2			
Muscogee		58	7	6	3	74	10	1	3	17	9	1	3	3	11	1	3			
Newton		7	3	0	1	11	1	2	0	1	4	1	2	0	1	2	0			
Oconee		3	2	2	2	7		2	2	4		2	2		2	2	2			
Oglethorpe		3	0	0	3				0				0				0			
Paulding		8	1	4	3	16	3	1	4	2	10	2	1	3	1	1	3			
Peach		4	1	1	6		2	1	1	4		2	1	3	2	1	3			
Pickens		3	1	1	1	5		1	1	2		1	1	2		1	1			
Pierce		1	0	0	1			1	0	1			0				0			
Pike		1	0	0	1				0				0				0			
Polk		2	1	0	3			1	0	1			0				0			
Pulaski		1	0	0	1			1	0	1			0				0			
Putnam		7	1	1	1	9	2	1	1	4		1	1	1	3	1	2			
Quitman		1	0	0	1			1	0	1		1	0	1		1	0			
Rabun		3	0	0	3		1	0	0	1		1	0	1	1	0	1			
Randolph		1	2	2	3			2	2			2	2		2	2	2			
Richmond		31	4	4	7	46	5	1	5	11	3	1	4	8	6	1	2			
Rockdale		5	2	1	8		1	1	1	3		1	1	1	3	1	1			
Schley		1	2	2	3			1	1				0				0			
Screven		2	1	1	3			1	1	1		1	1		1	1	1			
Seminole		1	0	0	2	3		0	2	2		0	2	2		0	2			
Spalding		9	5	2	16		1	3	1	5		1	3	0	4	1	4			
Stephens		2	3	0	1	6		3	0	1	4	3	0	1	4	3	0			
Stewart		1	0	0	1		1	0	0	1		1	0	1		1	0			
Sumter		6	1	3	10		1	1	2	4		1	1	0	2	3	1			
Talbot		1	1	1	3				0				0				0			
Taliaferro		1	0	0	1				0				0				0			
Tattnall		2	1	1	3		1	0	1	1		1	0	1	1	0	1			

# Appendix E

## APPENDIX F

### DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

#### **A-A**

African-American

#### **Child Abuse Protocol Committee**

County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

#### **Child Fatality Review Report**

A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.

#### **Child Fatality Review Committee**

County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health.

#### **Eligible Death**

Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

#### **Form 1**

A standardized form required for collecting data on all child fatalities by coroners or medical examiners.

#### **Injury**

Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

#### **Intentional**

Refers to the act that resulted in death being one that was deliberate, willful, or planned.

#### **Medical Cause**

Refers to death resulting from a natural cause other than SIDS.

#### **Natural Cause**

Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

#### **“Other” Race**

Refers to those of Asian, Pacific Islander, or Native American origin.

#### **“Other” as Category of Death**

Includes deaths from suffocation, choking, poisoning, and falls (unless otherwise indicated).

#### **Perpetrator**

Person(s) who committed an act that resulted in the death of a child.

#### **Preventable Death**

One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.

#### **Reviewed Death**

Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.

#### **Risk Factor**

Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

#### **Georgia Child Fatality Review Panel**

An appointed body of 16 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

#### **Sudden Infant Death Syndrome (SIDS)**

Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a “medical” cause.

#### **Trend**

Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.

#### **Unintentional Death**

Refers to the act that resulted in death being one that was not deliberate, willful, or planned.